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Calendar of Coming Events.

January, 1900.

Sat. 6.—Messrs. Golding-Bird and Dunn's take-in; Drs., G. S. Graham-Smith and F. W. Smith; Cl., W. G. Stewart.
1 p.m., Clinical lecture by Dr. Bryant.
G.H.P.P.S.—Clinical evening.
G.H.R.F.C., I.—Old Leysians, home.
II.—Rosslyn Park, away.
G.H.A.F.C., I.—Weybridge, away.
II.—Kenley, home.

Mon. 8.—Second part of Conjoint D.P.H. Exam. begins.

Tues. 9.—First Conjoint Exam. begins.
February Appointment List closed.

Wed. 10.—1 p.m., Clinical lecture by Mr. Lucas.

Thur. 11.—Messrs. Howse and Jacobson's take-in; Drs., F. E. Welchman and D. L. Morgan; Cl., C. T. Hilton.

Sat. 13.—1 p.m., Clinical lecture by Dr. Bryant.
G.H.R.F.C., I.—Croydon, home.
II.—Croydon, away.
III.—Polytechnic "A," away.
G.H.A.F.C., I.—Reigate Priory, away.
II.—Old Cranleighans II., home.

Mon. 15.—Pre. Sci. and Intermediate M.B. Lond. Exams. commence.

Tues. 16.—4.30 p.m., Meeting of the Dental Society.

Wed. 17.—1.15 p.m., Clinical lecture by Mr. Lucas.
G.H.R.F.C., II.—St. Thomas's Hosp., home.

Thur. 18.—Messrs. Davies-Colley and Symond's take-in; Drs., J. D. Bridger and E. Shelton-Jones; Cl., D. G. Greenfield.

Sat. 20.—1 p.m., Clinical lecture by Dr. Bryant.
G.H.R.F.C., I.—Rosslyn Park, home.
II.—Hammersmith, away.
III.—Beckenham, away.
G.H.A.F.C., I.—
G.H.P.P.S.—Paper by C. T. Hilton, "The pupil as a factor in diagnosis."

Guy's Hospital Gazette,

JANUARY 6, 1900.

On Convulsions.

CLINICAL LECTURE BY DR. PITT.

October 21st, 1899.

GENTLEMEN,—I propose taking up to-day the discussion of Convulsions, as we have had two or three cases, which illustrate some interesting points, in the wards recently.

The first case is that of a man of thirty, who was admitted in a state of coma, having been found in a convulsion in the street. At first the causation was obscure, but we finally came to the conclusion that the convulsions were due to plumbism. They recurred several times. The man remained in a state of coma for a considerable time, and, as far as we could judge, the convulsions appeared to have been general. But after he was in the ward the chief condition was one of rigidity. He had a series of tonic spasms, and the movements affected the extremities equally. His temperature ran up to 101·8° F., and finally, two days later, up to 104°. Practically he remained in a state of tonic spasm for forty-eight hours, and there is little doubt that the pyrexia resulted from the discharge of energy due to the tonic contraction of the muscles. When you have persistent convulsions, whether tonic or clonic, there is a tendency for the temperature to run up.

The man remained in a restless, noisy, weak-minded condition. There was difficulty in getting him to feed, there was great difficulty in getting him to answer any question; he was quite foolish, and practically this state of great mental and bodily disturbance lasted for a week. One night, at the end of a week, he went to sleep, and woke up the next morning perfectly sane and able to answer questions, without any evidence of disturbance. The symptoms then consisted of a series of convulsions, followed by tonic spasm lasting for forty-eight hours, and a condition of stupor for a week, ending in a sudden and complete recovery.

On enquiry from his friends we learnt that he had been in some lead works and had been invalided for some days on account of colic. He had a lead line at the margin of the gums, which was very slightly marked, but still it was visible. His hearing was normal, and there seemed no

other cause to account for his convulsions. As to alcohol, he had not been taking any alcohol to excess recently, although previously he had done so. Convulsions occur as the result of both acute and chronic alcoholism. So far as the effects of a bout of drinking are concerned, convulsions only occur when a man has quite recently taken a very large amount of alcohol. More than once I have seen a man become convulsed and pass into a state of coma after drinking a bottle of spirits. Convulsions may also occur in a chronic, sodden drunkard, when he has passed into the weak-minded, restless, mendacious condition which is not uncommon towards the end. We therefore excluded the probability of the convulsions in this patient being due to alcohol. The evidence that the condition was due to lead was not conclusive, but we failed to find any other cause, and thought that probably that was the true explanation.

Convulsions due to lead poisoning are not common. I have only seen two or three cases previously, which have all died. But Dr. Oliver, of Newcastle, who has seen a large amount of plumbism in the North, records that some of the patients, after remaining in a weak-minded condition for a shorter or longer period after the convulsions, recover.

The next case is an example of localized convulsions. It is that of a girl of sixteen, who, for the past seven years, has had occasional discharge from her ears, and who has opacites on both corneæ, the result of ulceration following measles some years ago. For a few days the girl had been out of sorts. She was admitted as a case of typhoid, with a history of a very severe headache, of having vomited, and the temperature was raised. After she had been in the hospital forty-eight hours her temperature had fallen, and in the morning she had a series of right-sided convulsions. Twenty minutes later she had a second, and a third about an hour after the first. The attacks began with twitching of the right hand, then the convulsive movement passed up the arm to the right side of the face, associated with deviation of the head and eyes to the right, followed by convulsive movements in the right leg. When the convulsive movements passed over to the left side of the body, the head and eyes deviated to the left, and the left arm, leg, and face were convulsed. After the attack it was noticed that the knee-jerks were absent. This is generally so after a convulsion. Immediately after a severe fit the rule is for knee-jerks to disappear, and when the patient comes to, the knee-jerk becomes exaggerated.

The girl had five more fits during the next hour, and when I saw her in the afternoon she was in a dull condition, and you could get very little out of her. She had intense headache. Her mental condition was quite different to what it had been a day or two previously. There was no optic neuritis, but on examination we found that there was a little moisture from pus in the left ear. On percussion the tenderness was not *local*, it was pretty *general*, but the percussion certainly increased her headache. There was no tenderness on pressure over the mastoid nor behind the ear; but taking the fact that the illness was an acute one—the headache was intense and the mental change very marked—it seemed quite clear that the origin of the trouble was aural. We asked Mr. Lane to see the patient, with a view to trephining, and he agreed that it would be wise not to wait, although there was some uncertainty as to the actual lesion. It was perfectly clear that with convulsions commencing on the right side, and becoming general, there was some irritation of the cortex of the brain. The point of uncertainty was as to whether we had temporo-sphenoidal disease, or an extral-dural abscess involving the dura mater. But even had the convulsions not occurred there probably would have been sufficient evidence to justify us in trephining on account of the sudden change which had taken place in the mental condition of the patient, and of the acute development of intense headache.

Upon opening the mastoid the cavity was found to be full of stinking pus, and, passing further along, a collection of pus was found between the anterior surface of the petrous bone and the dura mater. The fact that this abscess was limited to the anterior surface of the petrous bone, and did not involve the dura mater higher up opposite the motor cortex, made it practically certain that the convulsions had been due to something more than an extra-dural abscess. Upon opening the dura mater Mr. Lane found an abscess in the sphenoidal lobe, which he drained. Next day the girl was quite free from headache. There was considerable difficulty in keeping the track open, and when it failed to drain properly the intense headache returned, and the patient passed into a stupid, partially aphasic condition.*

In this patient there were recurrent epileptiform convulsions starting in the right hand, but becoming generalised, which were due to an

* After many vicissitudes, the patient gradually improved and is now convalescent.

abscess which had not destroyed the motor cortex, but which was in this region, and irritated the cells of the cortex, setting up convulsions. This is an illustration of the second group of lesions, viz., those which irritate the motor centres without destroying them.

The third case I need not go into at great length, because the convulsions were not very marked, but consisted of frequent localized twitchings. The cause—tuberculous meningitis—is not uncommonly the source of localised convulsions. The boy was five years of age, and was admitted with pyrexia. He was very dull, and had only been ill a few days. It was at first thought that he might have typhoid, but his temperature fell down to normal within three days, and it was obvious, on examining him, that his condition was due to tuberculous meningitis.

Causes of convulsions—

Epilepsy.
Hysteria.
Toxic conditions—
  Plumbism.
  Alcoholism, acute and chronic.
  Specific fevers, scarlet fever, measles, pneumonia and small-pox.
  Uræmia.
  Cholæmia.
  Tetanus.
  Hydrophobia.
  Cachexia, anæmia, etc.
  Cerebral anæmia.
Reflex irritation.
Tabes.
Insular sclerosis.
General paralysis of the insane.
Gross lesions of brain.
  Concussion, compression, laceration, etc.
  Pachymeningitis.
  Leptomeningitis.
    Tuberculous.
    Suppurative.
    Posterior basal.
  Tumour.
  Abscess.
  Softening.
  Hæmorrhage.
  Hydrocephalus.

Epilepsy is a difficult disease to define so as to exclude all the other conditions. Convulsions may be of two kinds. They may be either tonic—that is to say, a condition of persistently increased muscle tone—or clonic, in which the muscle tone varies, at one time being exaggerated and at another normal or diminished. We have still a good deal to learn with regard to the origin of convulsions. Dr. Hughlings Jackson's view is that a tonic convulsion arises from irritation of the cerebellum, and a clonic from irritation of the cerebrum. While that represents part of the facts in epilepsy—for as you know, the attacks generally begin with tonic spasm and pass on to clonic—yet the evidence is against the view that the irritation in epilepsy always starts in the cerebellum. It is not possible to ignore the fact that tonic spasm in certain conditions certainly arises from sub-cortical irritation.

How can you distinguish an attack as epileptic? The essence of epilepsy is that (1) the attacks are recurrent. You do not call a single attack of convulsions, epilepsy; the attacks must be repeated. (2) There is a sudden disturbance of the cerebral functions, with unconsciousness: but a convulsion is not essential, as in petit mal; and (3) the condition must arise from causes not outside the cranium. We may, therefore, take as a definition of epilepsy, sudden recurrent attacks of disturbance of the cerebral functions, associated with unconsciousness, not due to causes outside the cranium, and not due to gross intracranial lesions. It is difficult to classify the causes of convulsions at all satisfactorily; each classification has certain defects as well as merits.

One classification, which Dr. Hughlings Jackson suggested and which is interesting, although not easy to carry out, is that we should divide convulsive attacks up into, first of all, what he would call epileptic attacks which arise in connection with discharging lesions from the frontal area; secondly, epileptiform attacks which arise from discharging lesions in the motor area; and thirdly, pseudo-bulbar attacks which arise from discharging lesions in the pons, medulla and spinal cord. There is no doubt that there is a great difference between these varieties, but it is very difficult in many cases to decide, more particularly with regard to the first and third groups, as to which certain attacks belong. But this much is well established, attacks that begin in the motor cortex begin locally and with a clonic convulsion. Epileptic attacks, which often are due to a disturbance in the frontal region, begin with a tonic and are succeeded by a clonic convulsion. There is a considerable difference in the two series of attacks; in the majority of cases you can readily distinguish between the first and second groups.

There is a divergence of opinion as to whether epileptic attacks start with discharges in the region of the fourth ventricle, or in the region of the cerebral cortex. Formerly the view was held that epilepsy was due to cerebral anæmia subsequent to spasm of the cerebral arteries, and that this was the cause of the discharge of the cells of the cortex. This is a view which Sir William Gowers more particularly has combatted of recent years. He holds that there is no evidence at all in favour of a convulsive centre in the floor of the fourth ventricle, but that the evidence points to a discharge initiated in the cortex, due to instability of the tissue and not to an arterial spasm. It used to be supposed that the disturbance always started in the floor of the fourth ventricle. Another view which also used formerly to be held, is that the discharge arises from the cells of the motor cortex; whereas Sir William Gowers insists that recent histological observations seem to show that the discharge arises from the grey matter of the cortex and not in the cells themselves; that the cells merely transmit the chemical changes associated with a discharge of energy. It is certain that the cells of the cortex and the grey matter of the cortex are both constantly charged with energy which is ready to be discharged on a stimulus, and therefore it is perfectly clear, if they are always completely ready, that there must be a constant discharge of energy, although it may not be noticeable, and that epilepsy probably consists in either an increased rate of discharge or an increased instability. The regulative mechanism is so delicate that the moment there is a stimulus a response can take place, and yet normally the mechanism will not allow discharge to occur unnecessarily.

You will find that epilepsy runs in families; that epileptics generally have a history of epilepsy or insanity in the family. Probably, in some cases, they have imperfectly nourished grey matter which is unstable and deficient, and therefore discharges take place. So that, one view that may be held with regard to epilepsy, is that it is a condition in which either the regulative mechanism, or the rate of discharge of energy is abnormal. If a discharge has once taken place in any area, next time a smaller stimulus will be sufficient to produce it. This is essential to the well-being of the animal, because every movement that we acquire is due to the fact that, with practice, it becomes easier, and easier and finally automatic. With regard to the process of memory in the same way, repeated discharges in a certain direction tend to become more and more easy. So while it is essential that repeated discharges in any area should gradually establish a more or less definite path, in the same way you can readily understand that violent discharges in any area make it more easy for similar violent discharges to recur again. Nothing therefore predisposes to a fit more than a previous one. While, therefore, a series of recurrent fits constitute epilepsy, the first fit may arise from many causes, but if the cause is persistent, the tendency for fits to recur becomes more and more marked. Many cases are really often started originally from local causes.

EPILEPSY, then, is simply a convenient term for grouping the cases of recurrent convulsions in which there are no gross lesions, and in which the attacks are constantly recurring without any very obvious cause. They form a large and important group.

Convulsions due to HYSTERIA are not associated with loss of consciousness, and possess other characteristics which differentiate them from those that occur in epilepsy. Moreover, hysterical attacks are not so persistent as epilepsy.

REFLEX convulsive attacks.

In children, irritability is much greater than in older people, and numbers of disturbing causes which are sufficient to bring on attacks in children have no effect in the case of adults. A common cause in children is gastro-intestinal irritation. If a child has had a meal of indigestible food, or if it is constantly fed on unsuitable food, that may be sufficient to bring on a convulsive attack.

Chronic irritation due to worms, more particularly thread worms, is also a cause of convulsions in children.

In adults, reflex convulsive attacks, assuming that the patient is not epileptic, are rare.

There are a large number of TOXIC CONDITIONS which may induce convulsions.

I have referred to acute and *chronic alcoholism*. These are not a very common cause, but still they are important and have to be borne in mind.

In children convulsive attacks may occur at the onset of many of the *exanthemata*, and in many, convulsions replace the rigor in the adult. The specific fevers in which you are most likely to meet with convulsions are: scarlet fever, measles, pneumonia, and small-pox.

Uræmia in chronic Bright's disease, and sometimes in connection with pregnancy, is a frequent cause of convulsions.

Other toxic conditions are *cholæmia, tetanus, hydrophobia* and *plumbism.*

Two other conditions I have put down as toxic. First of all, the various *cachexiæ.* For example, if a child's nutrition fails, and it has no recuperative power, it may pass into a state in which convulsive attacks are not infrequent. Severe diarrhœa, heart disease, starvation, or profound anæmia, may all lead to convulsions.

Another frequent cause is a *great fall of blood-pressure,* whether due to hæmorrhage or other agency.

There are three important diseases in the course of which convulsions may occur, the mechanism of which is obscure. These are: INSULAR SCLEROSIS, TABES, AND GENERAL PARALYSIS OF THE INSANE. So far as we know, no definite lesion is found in the brain in those cases in which convulsive attacks occur, as distinguished from those in which it does not occur, except, perhaps, the perivascular lymphatics of the motor cortex are more distended with waste products. The attacks, as a rule, are general; sometimes, however, they are very much more marked on one side than the other. Only a few months ago we had in the Clinical ward a man with convulsions limited to his right side, followed by hemiplegia, which lasted for some weeks, and this ultimately turned out to be a case of general paralysis. It is unusual for the weakness to be so markedly hemiplegic; but convulsive attacks more marked on one side than on the other, are fairly common. There is no definite difference between the convulsions of these three diseases, but in all there is marked pyrexia. Convulsive attacks—unless they are recurrent, and you have a status epilepticus—are not, as a rule, associated with a rise of temperature, but in these diseases there is rapid rise even when there is but a slight convulsion.

LOCAL LESIONS.—First of all, *meningitis.* In all forms of meningitis you may meet with twitching passing on to more or less severe and generalised convulsions. It is of interest to note that an inflammation limited to the dura mater is capable of producing convulsions without any infection, so far as we know, of the meningeal covering itself.

The varieties are *tuberculous meningitis; suppurative meningitis,* which often occurs on the cortex as the result of injury, and various toxic conditions, such as influenza, pneumococcal infection and cerebro-spinal meningitis; and *posterior basal meningitis,* which is most common in small children under three years of age.

There are two or three points of importance to note in regard to convulsions in these conditions. In tuberculous meningitis, convulsions may occur at the onset of the illness, when they are apparently toxic in origin and fairly general; but later on in the disease the convulsions are localised. Very often you notice a twitching of a finger, or of one limb, or rigidity of a limb. You find, in children at any rate, the symptoms often are variable. One day the child will have its right leg rigid; a day or two later, the left. In many patients there is also a localised, clonic or tonic convulsion recurring throughout the illness. In adults, tuberculous lesions seem to be localised, and if in an adult you watch the twitchings, they are almost always the same, and not variable.

With regard to retraction of the head. You find temporary but not persistent retraction of the head with tuberculous meningitis. If a small child has meningitis with persistent retraction of the head, you may be quite certain that it is of the basal form. This runs a much slower course and is less certain to end in death; the head may be persistently retracted for three or four weeks continuously. When the upper part of the cortex is affected there is not retraction of the head, but convulsive twitching or rigidity, according to the portion involved. It is not clear that we can always distinguish a case with meningitis over the cerebrum from one in which the cerebellum is affected. But we may certainly lay it down that when the cerebellum is involved, if the middle lobe is affected, you have persistent opisthotonos; if the lateral lobe, extension of the legs with flexion of the arms in tonic spasm; whereas if the motor cortex of the cerebrum is involved you have twitching and convulsive clonic movements. So that on the whole there is a certain amount of distinction, but in many cases the symptoms due to the meningeal affection are so ill-defined that you cannot locate its seat.

As to the gross lesions of the brain which may set up convulsive attacks. I want, first of all, to insist that a lesion which destroys the motor centre for any particular area will not produce convulsions in the corresponding muscles. To produce convulsions you want to set up irritation in the neighbourhood of the motor centre: therefore, when there is complete hemiplegia, convulsions do not occur until the hemiplegia is cleared up. If the lesion has actually destroyed the motor centre there will be no convulsions.

On the other hand, if the lesion has only damaged the fibres and not destroyed the motor centre, then it is not infrequent to have what are called *post-hemiplegic epileptiform attacks*. Lesions in order to produce convulsions must be in the neighbourhood of a motor centre, but not destroy it.

Meningeal hæmorrhage will set up convulsions due to compression of the cortex, and so will *cerebral hæmorrhage* when the motor fibres are not completely cut through.

In *hydrocephalus*, though the mechanism of the process is not quite clear, there is no doubt that convulsive attacks are not uncommon and are probably due to anæmia.

The next group of cases is most interesting from a surgical point of view, it is that of recurrent convulsive attacks starting with clonic convulsions, with their origin always in the same group of muscles, which form *Jacksonian epilepsy*.

Amongst the lesions which set up convulsive attacks are *tumours*. The tumours which most commonly produce attacks are more or less stationary ones. The most common cerebral tumours are the syphilitic gummata and the tuberculous. They particularly tend to involve the cortex, and they often remain quiescent for months. When cerebral tumours grow rapidly they tend to form imperfect tissue, and hæmorrhage takes place, which may induce a convulsion.

Abscess is another common cause of convulsion. In the case I referred to, the abscess was in the temporo-sphenoidal region, and irritated the motor cortex without destroying it.

Then come *fractures* of the skull, with laceration of the brain. I am very dubious as to whether convulsive attacks occur with cranial fractures, unless there is also compression or laceration of brain tissue.

Many attacks arise in connection with old brain scars. As to the common causes of scars in the brain, by far the most common is *softening*, as this tends to affect the cortex and frequently is not immediately fatal. Cerebral hæmorrhage less commonly affects the cortex. The softening may be due to arterial thrombosis, which occurs chiefly with syphilitic endarteritis or atheroma, or to embolism due to heart disease; the last may occur in childhood. Venous thrombosis is an efficient cause in infancy.

I propose now to refer to some of the more important facts with regard to EPILEPSY. First of all, as to the question of heredity. In epilepsy there is no doubt that at least half the cases have either epileptiform or insane relations, and in such cases the attack is due to some defective nutritional condition of the brain. As to sex, there is not very much difference between the frequency of epilepsy in the two sexes, excepting that it is much more common for girls to break down after puberty and to start epileptiform attacks, than it is for boys.

As to the age at which epilepsy starts, about one-eighth of the cases begin during the first three years of life. A very considerable group of cases, one-fourth, begin with the development of puberty, that is, between the ages of thirteen and sixteen. Practically three fourths of all the cases begin before the age of twenty, and it is very rare indeed to find true epilepsy starting after the age of forty.

With regard to the causes which start epilepsy. Heredity is one factor, often epilepsy will follow on what appeared to be an ordinary attack of infantile convulsions, said to have been associated with teething. I think Sir William Gowers is quite right in insisting that we must bear in mind that children who are convulsed during teething are usually those who have been badly fed. The brain is slow to develop, and we may be perfectly certain that if dentition is tardy, the cerebral development is more so, and it is probable that the attacks are due to the associated delay of cerebral development, and the fits having once started, it is comparatively easy for them to recur with but slight disturbance.

The next group of cases in epilepsy are those that commence during an acute illness, such as measles or whooping-cough, and which are characterised by the great severity of the first attack. I saw a case last year of a small child who was previously perfectly well, but during an attack of measles she was seized with very violent convulsions, succeeded by a condition of chronic epilepsy. In such cases there is little doubt that some thrombosis or gross lesion has taken place in the brain.

Another fact of importance to which I would draw attention is the effect of fright. A very large number of cases of epilepsy are started initially by fright or great emotion. It seems that when an individual has suffered a sudden shock, if he can be kept active and not remain more or less paralysed with the fright, there is less probability of a fit following. As a result of fright, an attack of chorea or hysteria may come on immediately, yet it is comparatively rare for such to be followed by epilepsy; but if

no vigorous movements take place, and the discharge of the cerebral energy is inhibited, epilepsy may develop, starting a week or two later. It is quite a mistake to assume that convulsive attacks are necessarily hysterical because they are brought on by emotion. Undoubtedly many true epileptic attacks are initiated by emotion, and afterwards, in the same way, an attack may recur simply from fear, or excitement.

As to the appearances to be noted, and the main features, of an attack of epilepsy. If you enquire, you will find that in a very large number of cases there is some abnormal condition preceding the loss of consciousness; the aura, as a rule, is more or less constant in the same individual. The aura may be a sensory one—a rush of blood to the head, an epigastric pain, nausea, or an offensive smell, or, in fact, any sensory disturbance. Some of the visual disturbances are of considerable interest. In some cases you find flashes of light; in other persons you find that they have a sensation of blindness which comes on before they lose consciousness. In another group of cases patients appear to see images passing rapidly before them, and they are impelled to turn in the direction from which the image is coming. Here an attack of vertigo is followed by loss of consciousness and the development of the fit. As a rule the convulsive movements will begin on the same side as that towards which the object appears to move.

Besides these sensory auræ, there are states of extreme mental clearness. Some patients say that suddenly they seem to understand things previously obscure, and to have an excessively clear condition of the brain, which they know will in a short time be followed by an epileptic fit. In other patients there may be a condition of somnolence.

The movements at the onset are not universal. You find that although they may quickly become universal, there is generally a little difference between the two sides. Perhaps one side of the face begins to twitch before anything else is noticed, and if you see a person at the onset, you may observe that the eyes and head tend to deviate in the same direction. Very quickly, however, the whole body becomes rigid. A typical attack commences with a state of tonic spasm, although a little twitching may be present for a second or so, and in consequence of the rigidity, he necessarily becomes livid from semi-asphyxia; in about half a minute the spasms tend to relax. But they tend to recur again and again, the succeeding intervals become longer until a series of clonic convulsions evolve. With these clonic convulsions there is movement of all the limbs and frothing at the mouth. The attack very seldom lasts for more than a minute. If the violence of the attack lasts ten minutes or a quarter of an hour, you may be certain that it is not a true epileptic attack, but an hysterical condition. Though the convulsive movements in true epilepsy last a short time, they may be followed by a condition of post-epileptic coma or stupor which may continue for many hours.

Two important and common symptoms which occur are involuntary micturition and biting of the tongue. With regard to involuntary micturition, I do not think it is a mere accident; it is probably due to a spasm involving the bladder. In some patients you find that the spasm almost always involves the bladder and brings on involuntary micturition. In other cases you may have attacks without the bladder being involved, and then there is no involuntary micturition. So that this condition of involuntary micturition is not due to mere accident or loss of consciousness, but to a special spasm.

Tongue biting.—The tendency is for one side of the face to be involved more than the other at first, and for the head and eyes to turn that way. The tongue tends to deviate violently to one side, and it is this deviation which tends to cause it to be bitten. Therefore, if you can attend to a patient instantly, you are very often able to put a wedge between his teeth before the tongue has been bitten, because the tonic convulsions do not occur for perhaps half a minute.

Loss of consciousness. During an attack of minor epilepsy the patient loses consciousness, but only momentarily. In an ordinary epileptic attack of epilepsy major, which starts with the tonic and goes on to clonic convulsions, the pupils dilate widely, the eyes and head deviate, and the patient remains absolutely unconscious. If a patient takes any interest in what is going on, and catches hold of people while the convulsive movements are general, the attack is a hysteroid one.

In Jacksonian epilepsy there is often no loss of consciousness at the onset, but as soon as the convulsions have affected one side and pass to the opposite one, consciousness is lost, and in some patients even sooner.

In most cases of epilepsy the patients fall, and the fall is generally due to a sudden tonic spasm of the trunk and limbs, which is incompatible with the erect position. Attacks of petit mal may occur without the patient falling, but in severe attacks, when the convulsions are

general, he must necessarily fall. Do not, therefore, assume that because a patient does not fall, the attack cannot be epileptic.

Transfusion from a Clinical Aspect.

I.—INFUSION IN HÆMORRHAGE.

THE value of infusion in the treatment of anæmia due to hæmorrhage has been so strikingly demonstrated by results in the wards, that it is scarcely necessary to lay stress upon it. Numerous lives have been saved by prompt infusion. Vivisection has indeed been eloquently justified by the successful application of the results of Wooldridge's experiments to surgical practice. Bleeding at operations will ever remain a thing to be prevented rather than mended, but the gravity of severe hæmorrhage has been considerably minimised by the discovery of transfusion. The results of infusion have been so good in this condition that the treatment has been extended to other conditions where the *circulating* blood has become diminished in volume. The results have, however, been disappointing on the whole, and do not compare with those obtained in pure loss of blood.

To require transfusion a patient will generally have lost two pints of blood or more. Smaller bleedings can usually be treated by the free administration of water by the mouth or saline solution by the rectum.

It is curious to notice how carefully water is withheld from a patient after an operation. Vomiting is considered to be a calamity, and hence the cruelty, but as a rule the patient retains most of the water he gets, and vomiting cannot be so hurtful except in certain abdominal operations. Often the gratification of the thirst stops the reaching that occurs after an anæsthetic when the operation has caused considerable bleeding.

In rather severe cases, and where for any reason water cannot be given or retained by the mouth, a saline enema acts well and fairly quickly, and may be repeated; but quantities larger than a pint to a pint and a half are rarely retained per rectum even if very carefully given.

For any but moderate losses of blood, direct infusion into a vein is the best treatment to adopt, and the sooner it is undertaken the better.

The bleeding must have been arrested first, as a rule, but sometimes transfusion has to be used at once whilst someone else endeavours to arrest the hæmorrhage by pressure or other means.

No good results are obtained where the bleeding vessels cannot be controlled. Gastric and intestinal bleeding, and hæmoptysis are some examples of such conditions.

As one would expect, infusion does harm when the bleeding is not prevented. The blood is simply washed out of the vessels.

There is no degree of bleeding too severe for treatment by infusion. Marvellous recoveries have occurred in apparently hopeless cases. The following case impressed this upon me. A patient with carcinoma of cervix got secondary hæmorrhage ten days after incomplete removal of the growth. Plugging was twice tried, but was of no avail. The vessel was apparently the uterine artery. The patient was placed in the lithotomy position on the operating table. The clamps tore away pieces of friable growth and vessel time after time, until the loss of blood became tremendous. When at last the forceps obtained a firm hold, the patient was pulseless. Infusion was, however, immediately resorted to, and the patient recovered and lived some months afterwards.

Patients with *surgical* anæmia recover from it wonderfully quickly if one can only tide over the first day or two. A lady with a large intrauterine fibroid, during an attempt at enucleation, lost so much blood that the operation had to be abandoned and the uterus plugged. After infusion the patient rallied, and after a month she had so far recovered that an abdomino-vaginal hysterectomy was successfully undertaken by Dr. Horrocks. The uterus reached nearly to the ensiform, however, and bleeding was unavoidably severe. Transfusion was again performed and the patient recovered.

Transfusion *proper*, that is the transference of blood from one individual to another is happily as unnecessary as it is usually impracticable. The name has, however, become generally used for the injection of any liquid into the circulation *directly* by the veins or *indirectly* by the subcutaneous tissues. This is more correctly called infusion.

The indirect method is not very satisfactory, because

(i.) It is slow; the success of infusion largely depends on the rapid and early introduction of the fluid into the circulation. The fluid often takes a long time to get absorbed from the subcutaneous tissues and in the very worst cases may not be absorbed at all.

(ii.) Rectal injection is excellent treatment in moderate losses, whereas nothing short of the direct infusion is adequate or quick enough for the severe cases. A half-way measure between saline enema, and direct infusion, seems to me to be unnecessary.

(iii.) This method is sometimes the cause of considerable pain, much more than need be the result of the direct method.

In children who do not retain enemata it is more applicable, especially cases of diarrhœa and vomiting.

There are two methods of performing the direct infusion:—

(A.) The hydrostatic pressure method.

(B.) The method where a syringe is used.

A. is much better than B.

The funnel method will be described fully. The necessary apparatus consists of—

(i.) A piece of rubber tubing at least two yards long. The success of the method depends on length of tube, of course.

(ii.) An ordinary middle-sized glass funnel.

(iii.) A metal conical cannula, curved so that the venous limb, one and a half inches long, forms an angle of about 120° with the other, over which the rubber tubing is tied. The latter limb should be one inch long

and should have a calibre of about a quarter of an inch diameter. It should also have a rim around the edge. The venous end must not be pointed or sharp, but transversely cut and bevelled. This conical limb should have an extremity small enough to enter veins much smaller than the median basilic. This cannula will fit any vein and only has to be pushed in far enough to be firmly gripped. This makes the use of a ligature unnecessary. Sharp and pointed cannulæ are very troublesome, and pierce the vein and its sheath, leading to much delay and unnecessary pain to the patient. Dr. Horrocks has been using a cannula, similar to the one described, for some years. Glass cannulæ are to be avoided.

(iv.) A clip which can be quickly moved from shank of cannula on to the rubber tube. This apparatus is very inexpensive, and the cannula is the only part which has to be specially made.

The instruments necessary are a scalpel and a pair of dissecting forceps. A pair of scissors and of Spencer Wells' forceps may be useful additions. A few strands of horsehair or other ligatures are of great help but not necessary.

The whole proceeding should approach asepsis as nearly as possible without waste of time.

The solution should be prepared before the incision is made. Five pints of saline solution are generally sufficient. The solution should be at about 105° F. This allows for some cooling. The usual strength adopted has been ʒi. to a pint of sterilised water. Dr. Beddard, however, points out that this should be increased to about ʒij. to the pint to prevent the rapid loss into the tissues which occurs when the weaker solution is used. If this will serve to make the improvement more lasting it will be of great advantage.

The skin may be anæsthetised by means of eucaine. Sometimes a general anæsthetic, in small quantities, is indicated in hysterical and restless patients. They require very little, and stand it well.

The pain from the operation is, however, but slight, and quite bearable without any anæsthetic, general or local, and the whole thing can be performed in fifteen minutes.

The median basilic is usually selected, because it is so constant and superficial. The arm may be temporarily compressed to demonstrate the vein. An incision three-quarters of an inch long is made through the skin, pulled just to one side of and parallel to the vein, which is tied at the lower end of the incision, and the tails are left long. The vein is stretched by means of the ligature, and carefully opened longitudinally, the back of the knife being always kept directed towards the posterior wall of the vein to avoid puncturing this wall.

This is the part where hurry or carelessness may lead to trouble and delay. The assistant has meanwhile filled the funnel, tube and cannula with the solution and clipped the tube close to the cannula. He should mount a chair, and hold the funnel quite five feet above the patient's arm. The store of solution should be within his reach as he stands on the chair.

The cannula is introduced until it is gripped, and the clip slipped on to the shank of the cannula. The fluid usually runs in without difficulty and very rapidly, but sometimes the arm has to be manipulated or raised for a while, in order to start the flow. When a suitable amount has been infused, the tube is clipped and the cannula withdrawn, a finger being pressed on the vein above the incision. The ligature used may be removed or left in. A couple of horse-hair sutures are enough to close the wound. Any vein may be used; the median basilic is better than the cephalic, into which the solution runs slowly. In an emergency, ordinary tap water, or better, ice, may be added to boiled water, to cool it without introducing any serious risk.

Method B.—The large glass syringe used is very difficult to keep in working order. This has to be disengaged (from the short rubber tube used), for filling purposes at frequent intervals. This is both troublesome and dangerous, because air bubbles are difficult to exclude. I saw one man who, after the introduction of a few bubbles, looked very blue and ill for a few seconds. The cannula used is generally pointed and nearly straight, and is not conical.

This method is tedious, lasting at least twice as long as the method described above, and often much longer. This is a most important thing in a conscious patient. The flow is uneven and subject to variable pressure. At least one skilled assistant is required, whereas one can transfuse with the other method without a skilled assistant, or even without anyone to help, if necessary. This is the state of affairs that prevails in practice.

The apparatus is complicated, expensive, and liable to get out of repair.

The amount of fluid to be used varies, of course, with the loss, but usually in an average adult (who has about nine pints of blood) about four or five pints have to be used to do any lasting good.

In pure shock, one has seen no lasting good result from infusion. Often there is a temporary improvement in the pulse—often, perhaps, a prolongation of life—but sometimes death seems to be hastened. Fracture o pelvis, or avulsion of a limb, without any but slight hæmorrhage, rupture of a viscus, and *early* burns, are some examples of this condition where infusion has been disappointing.

Railway accidents, with hæmorrhage, rarely derive much benefit, perhaps on account of the preponderance of shock over bleeding.

In collapse.—

(*a*). Due to the loss of blood. This comes on within twenty-four hours in cases which have been allowed to drift without infusion (which may have been considered unnecessary), or have been insufficiently infused. One has seen several very good results from transfusion in such cases.

(*b*). Due to sepsis. No benefit arises from transfusion. Death may be hurried, as in one case I remember. The collapse of burns during first forty-eight hours is

probably largely toxic in origin, and that is why infusion seems to do no good.

(*c*). Due to vomiting and diarrhœa. Better results may perhaps be expected when repeated transfusions are adopted until the sp. gr. remains constant and near the normal, as suggested by Dr. Beddard for all cases of collapse.

Uræmia.—I. A case of uræmia terminating chronic tubal nephritis was bled 10 ounces and then infused. No diaphoresis or diuresis followed. The man died suddenly two hours later. This is clearly not the kind of case to infuse.

The following case of subacute surgical uræmia terminating calculous nephritis is both remarkable and interesting. Both kidneys were mere bags containing stones, but very little kidney structure remaining. An average of 32 grs. of urea were passed in twenty-four hours. The patient was tremulous, confused, and wasting rapidly, and scarcely slept at all. Diarrhœa and vomiting were troublesome. The patient looked dry and shrunken and was thirsty. The tongue was dry and brown, and the teeth covered with sordes. Infusion of five pints of saline relieved the suffering. Vomiting and diarrhœa ceased, confusion disappeared. The patient took farinaceous food well, and drank frequently. Diuresis was striking and 465 grains of urea were excreted in the first twenty-four hours in seven pints of urine. Patient slept well all night except for interruptions caused by the diuresis. The excretion was maintained at about 250 grains during the next ten days. The patient seemed to be very much better. A purgative had to be given and this seemed to re-start the old symptoms, so that after two days infusion was again performed with similar only more marked effect. The patient now made a will and saw her only child.

Some stones were removed from the right kidney (which was considered to be the better of the two) but all could not be dislodged. Soon again the urea diminished and vomiting re-started and the patient begged for another infusion. In all she was infused (directly into a vein) five times, each time with the same remarkable increase in the urea excretion and alleviation of symptoms. After the last infusion the urea excretion in the next twenty-four hours was about 560 grains.

The patient was, however, wasting rapidly, and died of heart failure about six weeks after coming under treatment.

After each infusion patient had a rigor, and also an irritable erythematous rash on the skin, and there was some diaphoresis.

Mr. Dunn, whose patient this was, has kindly allowed me to mention it.

A man comatose from cholæmia arising from cirrhosis was transfused, became rational and went home, but died within a fortnight. From a medico-legal point of view this may be interesting.

R.P.R.

With the Army Medical Corps in South Africa.

(BY OUR SPECIAL CORRESPONDENT.)

No. 1 General Hospital,
Wynberg, Cape Town,
Tuesday, November 28th, 1899.

In my letters hitherto there have been only distant glimpses of war; and we were getting tired of troopship-invalids and third-hand cases from Ladysmith. Now that is all changed. On Sunday last, the 26th, at 6 a.m., the first hospital train drew up at Wynberg station, bringing 103 cases straight off the field of Belmont, the battle having been fought on Thursday, the 23rd, and the train having left Belmont the following evening at 10 p.m.

The hospital train consists of about four or five long carriages, with two tiers of bunks ranged down either side across windows and doors the whole length of the train, leaving a passage about three foot wide between them. Theoretically it should have been easy to get at and look after each of the wounded as often as was necessary; but in fact as many patients were put into the train as the train could conceivably hold, and the passage was littered up with men in stretchers or men sitting about or lying on the floor. Consequently it was absolutely hopeless for the R.A.M.C. captain, the civil surgeon and the two nursing sisters to interfere in any way with the wounds. It was as much as they could do to administer nourishment and stimulants, and to keep the dust off the patients' faces. The line all along was cleared for the hospital train, and thus the 591 miles with four or five stoppages were accomplished in 32 hours. But, admitting the merits of this organization, one must also be deeply impressed with the terrors and dangers that these 32 hours on the railway must have imposed upon the 103 wounded travellers. The 103, with certain exceptions, were the most severely wounded that had survived and were considered capable of being further treated—compound fractures of the thigh of the most horrible description, bullet wounds of the skull with extensive fracture of vault or base, perforated lungs, fractured pelvis, and even bullet wounds of the abdomen with perforation of the intestine. Is it justifiable, we keep asking ourselves, to subject these terribly serious cases to the strain of such a journey? Of course the answer to this is strategical rather than surgical, otherwise one would say with the grumblers, who are many, that we ought to have been stationed at De Aar instead of Wynberg. Perhaps No. 4 General Hospital may go up there; but No 3, after a week's encampment by the sea near Cape Town waiting for its kit, is said to be under orders for East London; and No. 2 has established itself at our feet here. However, this is the arrangement now made, and to-morrow we expect two trains with the poor fellows from Graspan, and on Friday a hospital ship

from Durban, some 500 more patients in all; and there will be ample room for them all in our two hospitals, Nos. 1 and 2, with 300 beds to spare. The naval boys go on to the naval hospital at Simon's Town.

Of the 103 men shipped aboard the hospital train from Belmont three died on the journey, one body being put out at a station on the way, while those of Lieut. Burton of the Coldstreams and a Sergeant in the Grenadiers came on here, were brought straight up to our mortuary, and have been buried with full military honours. I had the privilege of examining both bodies. The former had an entrance wound, about half an inch across, situated an inch in front of the top of the left ear; and an exit wound, an inch across, in the horizontal line four inches further back. Between these two was a fracture into which one could sink one's little finger, although the skin was intact; and the bone all round the aperture of exit was pulped. Death had probably been caused by hæmorrhage from the ruptured middle meningeal artery. In the second case the wound was somewhat difficult to find, although a purulent fluid was bathing both ears. The entrance wound turned out to be a small opening just above the angle of the right jaw, from which the probe passed right through the skull and out at the left ear. The course of this bullet would make a good question for an anatomy paper.

I examined to-day a case that died after four days, from a bullet wound just below the crest of the left ilium, three inches behind the anterior superior spine. The bullet was found in the descending colon, in which it had made a large laceration; and a second neatly cut opening in the greater omentum looked like the effect of a second bullet, which, however, we were unable to find. The first bullet is in my possession, a long, fine Mauser bullet, nickel-coated, and not in any way distorted. One of my colleagues, on the other hand, Dr. R. V. Jameson, lately H.-.P. at Bart's. and a plague-officer in India, shows me two disfigured lumps of lead extracted from a shattered thigh; and these we take to represent the simple lead bullet of an old Martini-Henry rifle.

The fearful wounds we meet with in the thigh look as f they must positively have been the results of explosive bullets, and accusations are made against the Boers accordingly. But this accusation is probably quite false. Our soldiers took the kopjes at Belmont by the most gallant charges in the face of a withering fire; and with the tremendous muzzle-velocity of a Mauser or Lee-Metford rifle, even the hardest-coated bullets on striking a bone, especially in its diaphysis, will cause the most extensive shattering, and, driving the fragments through, will give rise to horrible lacerations at the site of exit. It is only the long-range shots, with the force of the bullet almost spent, that will drill a bone or get lodged without causing much damage.

The shattered thighs were for the most part opened up at once on arrival, under chloroform. Chloroform, by the way, is practically our only anæsthetic here, as it is almost impossible to transport large quantities of the volatile and expansile ether to these parts; and we are finding chloroform very satisfactory in many ways when carefully given. These thighs, then, were opened up freely, if necessary, and the loose fragments of bone of all sizes up to five inches in length removed, the cavity filled with iodoform and packed with sal-alembroth gauze, and the leg set at rest by a long Liston back and inside zinc splints. In a few days we hope to get proper extension apparatus fixed up, and if we can get the poles made we shall try Hodgen's, although it is surprising how little Hodgen's splints are known in other hospitals than Guy's. But the bad thigh cases are not doing very well, The mere fact that they came to us for the most part with only a field-dressing on, accounts for the fact that several were already suppurating; and one man whose limb was amputated in the upper third of the thigh this morning was found after the operation to have had a knee full of pus, and he died shortly afterwards. One of the worst cases, however, with an enormous hæmatoma all over the outer side of thigh and buttock, whose limb, on opening up, gave vent to the most fœtid smell ever experienced, is doing quite well on conservative lines of treatment.

We have done three trephinings—one for an extensive gash with laceration of the brain at about the apex of Rolando's fissure, and twitchings and paralysis on the right side of the body; another for a depressed fracture and extensive wound of the forehead; the third for a depressed fracture of the parietal on one side. These are doing fairly well, and the first is so fit that he has already sat up in bed and smoked a pipe.

Of course we have the usual list of prodigies. One man has a small entrance wound in the right flank and a small wound of exit in the left axilla. The wound is doing perfectly well, but there is complete paraplegia of the lower half of the body, with absent reflexes, and the cord is presumably severed at about the eighth dorsal vertebra. I know of at least one case in which the bullet has gone right through the centre of the right chest without causing damage; in another case the bullet passed nearly from one side of the neck to the other, between the trachea and œsophagus, causing dysphagia and but few other signs; while in a third a bullet through the neck and out at the axilla of the opposite side has produced wrist-drop on both sides.

There have been several shattered arms, and these are best treated by continuous immersion, splint and all, in boracic baths. Especial sympathy is felt for Mr. E. F. Knight, of the *Morning Post*, who was severely wounded in the right humerus by a shot from the top of a kopje, on which the white flag was already waving. The white flag was not of much use to the Boers on the kopje after that.

I met Dr. Darley Hartley, of South African League fame, to-day, with a GUY'S GAZETTE sticking out of his pocket. At present he is amongst the medical war-correspondents. Lieut.-Colonel Hodson, R.A.M.C., also an old Guy's man, is in charge of our surgical division here, and like the other officials over us is most considerate in his supervision. My colleagues are allowed

to do all the work for their own cases themselves, and I must say that their operative work has been extremely good, both skilful and well judged, although Colonel Stevenson, our consulting surgeon, has to be consulted before operation, and has occasionally vetoed it. But the aseptic Pharisee, like myself, naturally finds some of the methods of procedure hardly to his liking.

I am still in sole charge of the two medical wards, and to-day lost a typhoid at the end of the second week. On examination, under considerable difficulties, I found typical lesions in the intestine for a foot above the cæcum, with a large, presumably malarial spleen, weighing 35 ounces, a unilobular cirrhotic liver weighing 96 ounces, and extensive scarring in the groins, attributed to a mixed sore. And yet a fortnight ago this man came down from Ladysmith in perfect health, as servant to a wounded officer, who is now going home well. The authorities are going to leave me my "serious medical" ward, but will probably fill up the rest of the tents with these new surgical cases coming in, while room is made for them by shifting the slight medical and convalescent surgical cases into the marquees which constitute No. 2. This is undoubtedly the best treatment for the patients, as the marquees are detestable, but it will hardly please the officers of No. 2, and Hancock, who is of their number.

If the GAZETTE or hospital would like to send a really valuable Christmas present to the patients of Wynberg, they would send out a fully-equipped Hodgen apparatus, folding pole and all as a copy. It is terribly difficult to get these engineers to do original work, especially from bad designs.

Tuesday, December 6th, 1899.

Two hospital trains arrived last Wednesday, November 29th, bringing 200 of the less serious patients from Belmont and Graspan. The Spartan arrived from Durban on Friday, bringing 108 men from Estcourt and Mooi River via Durban, and this filled us up pretty well, to well over 600 patients; despite our having sent 75 home on the Orient. The next trainful that arrived, therefore—one from Modder River on Sunday, with all sorts of bad cases—necessitated the opening of No. 2 General Hospital, which has established itself in marquees at our feet, 8 beds to a marquee, and 60 or so marquees. No. 3 General is to be established at Rondebosch, half-way between here and Cape Town.

We have had no series of cases so bad as those in our first lot from Belmont. Mr. Makins, of St. Thomas's, is operating in the stationary hospital at Orange River, and we suppose they are filtering off the more seriously wounded. We hear of three laparotomies, one of whom died afterwards, and was found to have had no less than 32 perforations of the gut. This strengthens one's belief that abdominal cases are the last that should be operated on, when, as on active service, there are so many others waiting for operative treatment which, in their case, is likely to be really serviceable.

Our high fractures of the thigh are all doing very badly. They are fearful wounds; and the prognosis is almost hopeless. I have such a case from Belmont and can speak from vivid experience. In this man the entrance wound was just below the great trochanter, the exit close to the tuberosity of the ischium. He came down with a long Liston's splint, which made a great sloughing ulcer on his ankle; but that is a detail. Dressing is extremely painful and has to be done under chloroform daily. The wound suppurates profusely despite any amount of iodoform emulsion; and one can only pack it when the discharge soaks through the dressings, as the patient could not stand a second dressing in one day. In the absence of a water-bed, our only one being already in use, and with the difficulty of turning the patient over to look after the back, extensive bed-sores have developed. The patient is sore when lying on his back. Despite the extension-apparatus he is in great pain when on his side. He is developing pustules on his chest and face; and he simply craves for morphia. Two very similar cases have died; one may possibly recover; this case is almost hopeless. In fact we almost believe that a primary amputation is indicated in these cases. But we are not yet aware of the results of primary amputations they have obtained at the front, and on that must depend our final opinion.

As to the nursing, I can only say that the whole system here appears to be entirely inadequate, and that for no reason, since there are a thousand civilian nurses in England and the Cape willing and thirsting for the work; and there are few things for which the tax-payer would so willingly pay. Hitherto there have been seven sisters on day duty, and two on at nights for the whole of our 600 beds, spread out over a space at least a quarter of a mile in diameter each way, and on the side of a hill. Practically the whole nursing is meant to be done by orderlies, two to each hut of twenty-five beds; and these orderlies have to go round with the officer each day; help in the dressings; go and order the meals and fetch them from the cook-house; scrub the ward and the furniture and appliances; fetch the medicines from the dispensary; and, in addition, do the nursing. This being the case I went into one of my huts on Sunday and found that my head-nurse, so to speak, was confined to cells for being drunk on the previous night; and the one remaining orderly said that was nothing, as he had had eleven days not long ago, and lost his corporal's stripes after fourteen years' service! And then the day orderlies have to take it in turn to be on night duty as well as day; there are at present so few orderlies in the place that they practically have to be on night duty as well as day every other night. What can one expect under such conditions? Little wonder if we get bedsores. Of course, with a good orderly, and patients able and willing to help, as in one of my huts, all goes fairly well; but even so the staff is quite inadequate. We ought to have one nursing-sister and four orderlies on for each hut, and then all would be well, even allowing for an occasional

night in the cells, which I suppose is a necessity. Well, a merry Christmas to Guy's. Do it well, as usual.

Monday, December 12th, 1899.

This mail leaves the Cape in a state of great anxiety at the rumour of 700 lost in the Stormberg disaster, and of a fruitless 12-hours' fight at Spytfontein. We are so surrounded here by Dutch sympathisers on the one hand, and military censors on the other, that it is almost impossible to say whether the news that filters through has been grossly exaggerated by the disloyals or minimised by the censor. In any case we have to wait for our weekly papers from home before we can get any really credible summary of events. At present No. 2 General Hospital is expecting a trainful to arrive at any moment, containing the convalescents and other contents of the field and stationary hospitals, probably not a very interesting lot. But after this reported battle outside Kimberley, there should be enough acute cases to fill all the empty beds in No. 1, and to open No. 3 as well. No. 3 General Hospital is to be opened at Rondebosch, halfway between here and town, under canvas, of course, like No. 2; and No. 4 only arrived yesterday, and still awaits orders.

Our work at No. 1 has been getting easier every day since we filled up ten days ago; and the greater part of it is now practically back-surgery work, with the double advantage of the air at Wynberg and of the confinement to hospital, and therefore to supervision until the patients are absolutely fit for duty, or are discharged and sent off to England as being unlikely to be fit within two months. The rapidity of healing has been quite marvellous.

There have been a few more routine operations this week; for instance, a popliteal aneurysm, which Dr. Thornton, of the Fountain Fever Hospital, cut down on to-day, ligaturing the ends of the vessel. This is our routine treatment here, the ends of the injured vessel being usually good and capable of bearing ligatures. The case of axillary aneurysm, of which you heard in my first letter home, has done extremely well, and was walking about comfortably a week ago. As orderly medical officer the other day I was called to a case under a colleague, of chest-wound, with pneumonia—hæmo-thorax and no pulse—on one side, indicating, it is thought, an aneurism. We had a lengthy discussion the next day as to whether it was justifiable to aspirate the chest under such a condition; and the final decision was in the negative. At present the patient has survived.

The Röntgen-ray work is now in full swing and is perfectly invaluable. We have an admirably fitted room with dark-room opening out of it, with a full Mackenzie-Davidson localizing apparatus and other paraphernalia, largely arranged by my colleague, Mr. Fox Symons, lately H.-S. at St. Thomas's, and one of the *Daily Chronicle* expedition in the Greco-Turkish war. As he, however, has most of the wounded officers under his care—he amputated Mr. E. F. Knight's arm recently at the shoulder and has done by far the best work in the place—the skiagraphic work for both General Hospitals here has been taken over by Mr. Henry Cantling, who, although a junior student, does most of the skiagraphic work at St. Thomas's, and has been sent out expressly for this work. The case may be instanced of a Lance-Corporal of the West Yorkshire, now under my care, who came out with me on the Roslin Castle, was wounded in the thigh at the Beacon Hill fight outside Estcourt, on November 23rd, and arrived here by the Spartan a fortnight ago. He had a small granulating wound at the back of the thigh; with the tungstate screen no bullet could be found in the limb and the bone was intact; so the wound was considered to be due to a shell. Mr. Cantling, however, found a bullet by the screen and localized it by a skiagram yesterday. It was 74 mm. or three and a half inches from the posterior surface of the limb, and its nose an inch from the bone; and from its shape he felt sure it was a Martini-Henry bullet. To-day I made a two-inch incision on the back of the limb, and without much difficulty worked right down to the bullet which could only just be reached at the full length of the finger, but was easily extracted by bullet forceps. It was a Mauser bullet flattened out from side to side with its nickel-casing split down the middle. It must have glanced off a stone and ricocheted into the man's thigh. An hour after he was found smoking a cigar against orders, and in two days he will be shipped off home.

Four of us went up Table Mountain on Sunday—a terrific climb—and at the top were kindly entertained by the Government Ranger in his cottage, a very lonely place. Curiously enough he turned out to have come from Hampton Court and to have been a patient to the father of one of my colleagues. He gave us an interesting account of snake-bites, which are not uncommon in these parts, and showed us a bottle of anti-venenin serum from the Pasteur Institute, and a hypodermic syringe with which the Government supply him. The poison, as a rule, is very rapid in its action. A general œdema seems to set in, with utter collapse, and death takes place in three or four hours, of which he gave us a few instances. Not long ago he found a native who had been poisoned one-and-a-half hours before and was moribund. He injected 10 c.c. of the serum and the man rapidly came to; was removed the next day to the Somerset hospital, and in a few days was discharged. This forester had saved a dog's life in the same way. He also showed us a good pustule on the arm of his child, whom he had vaccinated four days previously. Such is the reach of science at the end of the 19th century. F. E. F.

Papers by Guy's Men.

A Case of Interstitial Myoma of the Uterus. By Thomas Alph. Buck, M.B. Lond.—*British Medical Jonrnal*, 30th December, 1899.

With Dr. Hale White in the Wards of Guy's Hospital. —*Clinical Journal*, 27th December, 1899.

Nursing Notes.

RESIGNATION OF MISS NOTT BOWER.

IT is with much regret that the news of the Matron's ill-health and consequent resignation was received by all interested in the nursing work at Guy's. We understand that it was owing to the peremptory orders of her medical advisers that Miss Nott Bower was compelled to give up her duties.

Miss Nott Bower commenced her training in Guy's Hospital under Miss Victoria Jones in 1883. She filled the position of Sister in Dorcas ward, and was appointed Matron in the Huddersfield Infirmary in 1888, and returned to take charge of the Private Nursing Institution in 1889, until her appointment as Matron on January 25th, 1893.

During Miss Nott Bower's tenure of office, the whole system of nursing has been re-organised, and amongst many other improvements may be mentioned;—

1. The institution of the Nurse's Cycling Club of which Miss Nott Bower was the honorary treasurer; also the Nurses' Choral Society, the meetings of which took place in her drawing-room.

2. The midnight meal for the nurses which has proved such a boon to them on night duty.

3. The new hours off-duty, the average working of the nurses now only being eight and a half hours instead of over ten hours, the value of this alteration has been seen by the number of nurses off duty through ill-health being much less.

4. The change of uniform, viz., the cap of the "Sister Dora" style, and the aprons being provided with bibs and straps, altogether neater, more nurse-like, and more becoming.

5. Nurses being allowed to go to any church service on Sundays, outside the Hospital, instead of being obliged to attend the Hospital Chapel Services.

6. A portion of the Park being set apart for the use of the Nursing Staff during their off-duty time, which has given much pleasure and enjoyment to them all.

7. The formation of the Nurses' Recreation Society, which will consist of an amalgamation of the Cycling Club, Choral Society, Nurses' Library, Tennis Club, and also a Gymnastic and Swimming Club, and Literary Society, the three latter to be formed as soon as possible.

A Club cottage has been built, consisting of a large tea-room and two bedrooms, so that Nurses may spend a day or two in the country, and spacious cycling accommodation is provided, and several tennis courts.

It is unfortunate that Miss Nott Bower will not see the completion of the Henrietta Raphael Nursing Home as Matron of the Hospital.

We hope that after a long rest Miss Nott Bower will be able to undertake some less arduous work, whilst continuing her interest in all connected with Guy's.

The Governors, at their meeting yesterday, formally appointed Miss Esther Young as Matron of the Hospital. Miss Young had been marked out by the whole Nursing Staff as the successor to Miss Nott Bower in one of the most honourable positions in the nursing world. Her appointment will give satisfaction to all concerned, and we wish her many years of happiness.

Case for Diagnosis.

C. W., aged nine years, was admitted for marked drowsiness, vomiting, and ptosis of the right eyelid. He had had a discharge from the right ear for the last three years, and lately had been attending Out-patient's for this reason. Two days before admission, patient was seized with a very severe headache, followed by continuous vomiting.

On admission—He had marked ptosis, dilatation of the pupil, external strabismus, and commencing optic neuritis on the right side. He was very drowsy, but would answer questions intelligently; his right ear emitted a very foul discharge. Pulse 56, respiration 24, temperature 95·4° F. Two days after admission, patient was trephined over an area situated one and a half inch behind and above the external auditory meatus. The meninges were apparently healthy, and the brain substance, although somewhat bulging, pulsated freely. Exploration failed to reveal pus within the range of an ordinary hypodermic needle. Patient's temperature, which had gone up to 100° F. on the day of the operation, remained about the 99° level for three days, and then fell below normal for a couple of days. On the succeeding day it again rose to 100°, and right-sided convulsions developed, chiefly of the muscles of the upper limb, while intermittent opisthotonus and rigidity of the limbs, with modified Cheyne-Stokes' breathing, was noticed. Patient's general condition grew worse, and on the next day an exploration was made of the mastoid cells. The lateral sinus was exposed during the operation and was found to be pulsating freely. The mastoid antrum was found to contain a little pus. During the night following this exploration, patient's temperature rose to 106° F., pulse 136, respiration 44, and death ensued the following morning.

(*For solution see page 28*).

Christmas Ward Fund.

THE Fund amounted this year to £98 2s. 6d., contributed as follows:—

	£	s.	d.
C. R. G. Hoare, Esq.	5	0	0
G. Shaw Stewart, Esq.	5	0	0
Dr. Savage	1	1	0
From the Dental School, per A. E. Rowlett	7	2	3
" Dissecting Room, per Mr. Robertson	6	9	6
" Pre. Sci. Class, per Mr. H. H. Carter	4	2	0
Proceeds from Smoking Concert	8	11	6
Collected by the Residents	60	16	3
Total	£98	2	6

H. W. BRUCE.

Passim.

IT is with the very deepest regret that we have to announce the resignation by Mr. Davies-Colley of his post on the Surgical Staff. Although he had been in ill health for some time previously, no one had anticipated his sudden resignation, which was due to increasing illness and consequent medical advice. Of the loss to the hospital we hardly like to speak. No member of the Staff was more unswerving or painstaking in the thorough performance of his duties, and to Mr. Davies-Colley the welfare of his patients was the one idea of his life. Throughout the whole hospital, where Mr. Davies-Colley has always been universally admired and respected, there is a feeling of real personal loss at the severance of his connection with Guy's.

WHETHER the year 1900 commences the twentieth century or not is a question which may very well be left to purists; for us it is sufficient that new year commences for the GAZETTE and all at Guy's. During the last year steady progress has been made throughout the whole Hospital, in the direction of necessary reorganization and rebuilding, and though the money we so badly need has been coming in slowly, it has come in steadily; it is to be hoped that the spontaneous and enormous outburst of charity in the direction of matters warlike will not seriously affect our funds or cripple the resources of the hospital. The work of the hospital is big enough and is steadily growing, and any retrenchment, however small, would be a serious matter to those dependent upon the hospital's efficiency. So we must wish Guy's Hospital and all within it a happy and prosperous New Year.

THE resignation of the Matron came as a most unexpected and unpleasant surprise to the majority of people at the hospital. Though it was known that her health had been but poor for some time past, it was not in the least expected that she would have to give up her work at the hospital so suddenly. But peremptory medical orders brook no delay and the Matron's departure became unavoidable. It is to be hoped that a prolonged rest may sufficiently restore her health to enable her again to take an active place in the nursing profession of which she was for so long such a prominent member.

MISS NOTT BOWER had been at Guy's for eight years and during her time many important reforms, for which she was very largely responsible, have been made in the nursing world at Guy's. A fuller account of the Matron's work is given in another column, but we may briefly state that the present system of longer hours off duty, the new Club House at Honor Oak, the present system of Sisters' appointments, and many other improvements in a nurse's life at the hospital are due to her initiative, and this is no small work for any woman.

ON her departure the Matron was presented by the Treasurer with a gold watch and chain as a mark of the esteem in which she was held at the hospital, and at a meeting of the Governors a resolution of regret at her unavoidable resignation was passed unanimously.

SISTER ESTHER, formerly Assistant Matron, as was generally expected, has been appointed Matron in succession to Miss Nott Bower, and her appointment has met with a universal chorus of approval. Sister Esther has been Assistant Matron at Guy's for some time, and is thoroughly acquainted with the spirit and ways of the hospital, and she should have the satisfaction of knowing that she starts her career with the good wishes of all at Guy's. The post of Assistant Matron has been officially filled by Miss Hodges, the present Sister Mary, but she will not commence active duties for a month or two.

CHRISTMAS went off with its usual success this year. Concerts were as numerous, as long, and as crowded as ever, and the sound of singing was never absent for long during the whole of Christmas week. The Niggers on Christmas day went the same old round; the Out-patients' Christmas tea was larger, noisier, and more successful than ever; then punctually by Saturday night last all the decorations disappeared, and now the hospital goes its daily round again as if nothing had happened, except for a few stray bits of ivy in inaccessible corners of various wards.

NOTWITHSTANDING the pressing appeals of patriotism, the money subscribed by the men for the Christmas Ward Fund beat the record this year, reaching the magnificent total of £98 2s. 6d. In this place it may be as well to correct two popular errors, one mostly rife

inside the hospital, the other out of it. Firstly, the money subscribed by the men does not go towards the patients' Christmas dinner; that is provided by the hospital and by the hospital alone. The Christmas ward fund goes to help meet the very large expenses necessary to decorate the wards and provide for teas at concert times, and also for other little luxuries for the patients. Even the large sum collected this year needs ample reinforcement from other channels to defray these large expenses.

Secondly—and this error is common outside the hospital—it is sometimes supposed that the Out-Patients' tea to children on Christmas day is provided for either wholly or in part by the hospital authorities with the hospital funds, and there have been objectors to what is thought by some to be an unwarrantable use of the public subscriptions. Again, this is not the case. The Out-Patients' tea is entirely provided for by voluntary subscriptions collected entirely for that purpose, and is managed by a committee unconnected with the hospital management. A proper understanding of these two points may help to clear the air for the future.

MR. FREMANTLE'S letters continue to show what a large field for medical and nursing work there is in South Africa, and how hard-up for some appliances the medical men are out there. In response to an appeal from Mr. Fremantle in one of his letters, we may state that a complete Hodgen thigh splint outfit has been sent out to him at his own expense, so that others may be copied from it on the spot. If any reader of the GAZETTE cares to help to defray the cost of this small expense, and make the inmates of Base Hospital No. 1 a New Year's present of the most useful sort, subscriptions will be thankfully received at the offices of the GAZETTE.

THE stream of men and nurses from the hospital to the seat of war continues. Miss Tippets left for South Africa on the same day as Lord Roberts, Miss Creighton (Sister Stephen) leaves to take charge of the Hospital Train to-day, Sister Martha (Miss Davidson) leaves very shortly, and the best wishes of all at Guy's will go with them. Meanwhile, Lieutenant H. W. Barrow, R.A.M.C., who was to have gone out earlier and was stopped by an attack of Enteric fever, sails shortly; Mr. F. E. Walker leaves next week, and Mr. K. B. Alexander most probably leaves the week after, both the latter going as Civil Medical Officers attached to the Army Medical Corps.

AMONG other men at the front we also note that Surgeon E. P. Mourilyan, R.N., of the *Doris*, is serving with the Naval Brigade at the front, and Lieutenants R. E. E. Phillips and C. R. Evans have been detailed for duty with the Seventh Division of the South African Field Force.

WE are requested to announce that Mrs. Pye-Smith, of 48, Brook Street, Grosvenor Square, appeals to ladies connected with Guy's Hospital for subscriptions towards comforts for the sick and wounded in Princess Christian's Hospital Train. The train, as stated above, is in charge of Sister Stephen, of this hospital. Subscriptions will be gladly received by Mrs. Pye-Smith at the above address.

OF all the acts of patriotism in which the Colonies have shown themselves pre-eminent in the present war, none exceeds that of Mr. J. Bettington of New South Wales, a former Guy's man, who has supplied the Australian contingent with £1,000, and £500 worth of tinned meat. Mr. Bettington is one of two brothers who were both at Guy's a few years back, but owing to family bereavements, and the necessity of going back to Australia to look after his estate, he never qualified, and has given up the medical profession. When his act of generosity became known at the hospital, a telegram was sent to him by several of the senior men and old friends, expressing their appreciation of his public spirit, and the pride which his old hospital felt in him.

WE regret to chronicle the death of Mr. John Gorham, of Tonbridge, which occurred December 13th last, the result of influenza. Mr. Gorham was a Guy's student, an old member of the Physical Society, and qualified in 1839 at the College of Surgeons and the Apothecaries' Hall. In earlier life he wrote much upon medical subjects, and was one of the earliest practical exponents of the operation of ovariotomy. In later life he gave up practice entirely and devoted himself to scientific pursuits, notably Botany, Crystallography and Physics. A very widely-read, large-minded man, he attained great eminence in the scientific world, and his death will rob the town of Tonbridge of one of its oldest and most distinguished citizens.

WITH reference to an illustration of Brinklea Sanatorium, Bournemouth, which appears in another page of the GAZETTE, we should like to remind our readers that the medical superintendent of that sanatorium is an old Guy's man, Dr. Kinsey Morgan. In these days when phthisis is being considered, and quite rightly, as a curable disease, amenable to open-air treatment and good food, it is desirable to know of sanatoria in England, and the south coast especially, where the now famous Nordrach open-air cure can be effected. A recent publication, "British Sanatoria for Consumptives," gives all the necessary information on the subject, with particulars of all the well-known English Institutions.

OF all the recent improvements to the hospital, none is more advantageous, from the hygienic point of view, than the thorough installation of electric light which is being established. But while the hospital is served by an outside company, of the inefficiency of the present one, this same electric light is most often conspicuous by its absence. During the whole of Christmas time the hospital has been plunged in darkness almost daily, at the hours between 5 and 8, when the light is most needed, and work in the surgeries, theatres and wards has to be carried on by the light of stray gas jets and hand-lamps. In the near future it is hoped to make our own electricity on the premises, and we shall be better and more efficiently lighted.

To shortly chronicle the doings of the football men; it will be seen in another column that Mullins has been elected captain of the United Hospitals team for the present season. A team is going to play the Stade Francais, and, possibly, the Racing Club, at Paris, leaving London on the 13th inst. Those who would play if selected, are requested to communicate with the captain.

OWING to the hard frost it was found impossible to play the London Scottish at Richmond on the 16th December, and the fixture was accordingly scratched. The second half of the season commences to-day with the return match against the Old Leysians, and, though the team is below its full strength, it should give a good account of itself at Honor Oak Park.

IT is to be hoped that the absentees will soon be able to turn out, and that more keenness will be displayed both in training and on the field, as it will be seen from the Cup Tie draw that we shall have to make a hard fight for the Cup if we are to keep it this year. One or two of our rivals are prophesying that it is not to remain in the Smoking Room at Guy's, and, judging from the strength of some of their teams, this seems not unlikely unless we show more determination in the matter. Want of spirit in the cup ties has never before been a feature at Guy's, and if we make up our minds to retain the trophy, retain it we shall however unfortunate we may have been during the earlier part of the season. It is about time for the team to assume a more definite constitution, and, as there are places open in both the back and front divisions, we shall look for spirited competition among the various "possibles" who should remember that it is only by dint of constant effort and training that they can make their selection certain.

WE hope, too, that the junior men will endeavour to keep the fourth fifteen going, and by some little self-sacrifice on their own parts, assist their energetic, and much-tried captain.

THE New Year's Honours List contains one detail of great interest to Guy's men Dr. Wordsworth Poole has been decorated with a C.M.G., in recognition of his services on the Niger. It will be remembered that the Guy's nurses who went out to the Niger and worked under Dr. Poole, also obtained signal recognition of their services, so that Guy's has evidently made its mark in West Africa. Dr. Wordsworth Poole has now left to take up his duties at the British Legation in Pekin.

WE would remind our readers that the subscription of twelve shillings and sixpence to the Clubs' Union, for GAZETTE and reports, fell due on the 1st instant, and should be paid as soon as possible to Mr. S. H. Croucher, at the Medical School Office.

AN index and title-page has been prepared for the volume just completed, and subscribers can have their sets bound at 1s. 6d. a volume by leaving them with the librarian. The binding is in two shades of blue—navy blue or a lighter shade—with the arms of the hospital in gold.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Christmas Week.

As usual the occasion was celebrated in the hospital by a Christmas dinner, provided by the hospital for all patients who were able to take it, the privilege of smoking in the men's wards, and the time-honoured performance of a travelling nigger show by the Residents and a few other students. Owing to a recent railway accident the surgical wards were fuller than usual, but the majority of these patients were happily in a sufficiently advanced state of recovery to thoroughly enjoy the proceedings.

Of the niggers there was a larger number than usual, thirty-two starting upon their enormous round at 1 p.m. With very few exceptions, all the Residents were in the troupe, and several junior men and old "Disguysed Minstrels" gave their services. The dresses were of a more than usually successful character, chiefly by reason of their variety and bright colours. Mr. E. W. S. Rowland, the President of the Residents, who took the hard rôle of "Massa Johnson," had a most imposing costume, half-way between that of a cathedral beadle and a port admiral, with a cocked hat, wig, and staff, not to mention shoes of Herculean size. The best "get up" in the troupe was undoubtedly that of Mr. H. W. Bruce, who, attired in the most dilapitated of tramp garments, looked his miserable and despondent part to perfection. Mr. R. W. B. Hall, as a schoolboy of the early thirties, and Mr. T. P. Berry as a girl, were two more exceptionally successful "creations." The niggers were accompanied by a large band, consisting of some seven or eight of that weird instrument the Phunnyphone, backed up by a bass drum, side drum, triangle, guitar, a concertina with one note broken, and the ever-helpful Mr. Edward Cohen on his famous fiddle. This galaxy of talent, playing alternately the "Soldiers in the Park," and the march from "El Capitan" with haunting insistency and varied intonation, performed the processional and recessional music during the whole afternoon, and this part of the programme was not the least popular by far.

Of the vocal part of the round we have nothing but praise; it is no small task to bawl your hardest in choruses and be really funny in twenty-one different wards on a diet of frequent tea and cakes, and this year's group of niggers were quite up to the usual excellent standard and equal to their task. Of comic singers Mr. H. Wacher was undoubtedly the best, and scored uniform success with a mock patriotic ballad, "That's how I saved my life," and the old favourite "My Gal Susie." The other cornermen were Mr. A. A. Miller, who sang "Mary was a Housemaid" *once*, and afterwards "The wide, wide world"; Mr. J. B. C. Brockwell, Mr. J. E. Collins, and Mr. Frank Cross, who also scored heavily with the "Fusiliers," another pseudo patriotic effort. Mr. H. Parrott sang "The Absent Minded Beggar" with enormous success and amid continual applause, the more so as all the patients had the words of the poem printed on their programmes.

Of the other numerous singers it is impossible to speak in detail as a criticism of twenty-one performances would tax our reporting power too greatly. The thanks which is so deeply owed to all these gentlemen was, we hope, brought home to them by the enthusiastic reception in the wards.

As the end came near in the Surgical Wards the spirits of all revived to greater efforts, and a last and excellent show was given as usual in Astley Cooper, which was packed from end to end. The troup then broke up and fled to enjoy their Christmas dinner which was provided by the generosity of Mr. Cosmo Bonsor and some of the Governors of the hospital. The wards were all lit up as evening came on and the hospital looked typical of Christmas, dull and grimy without, but light and cheerfulness within.

As in former years, we have again to thank Messrs. Ash & Co., the Printers of the GAZETTE, for their great kindness in providing a most artistic programme of the proceedings to every patient free of charge, as their share to the Christmas entertainment at Guy's.

WARD DECORATIONS.

The question must have arisen at one time or another in the minds of all who work in the wards during Christmas times, whether the profuse decorations erected, and numerous concerts given throughout the hospital every Christmas, justify their existence and the labour of arranging them.

There are those who say that decorations are not needed, that a bunch of holly on the gas bracket is all that is wanted to remind the patients of Christmas, that festoons, holly and ivy of all sorts are injurious to the patients by reason of the dust which they collect; in short, that decorations are needless and a nuisance. There are others that say, with occasionally more semblance of truth, that the last people to be considered at ward concerts are the patients for whom the concerts are ostensibly given, and that the performances are rather the occasion for informal social gatherings between the nursing staff and students, together with a fair sprinkling of fond mothers and sisters, and the gifted relatives or friends who play or sing for their enjoyment. As a matter of fact the good which the general decoration of the hospital and the ward concerts do is incalculably greater than the small amount of suppositious harm advanced by the croakers. The patients like the cheerfulness and gaiety of a Christmas week, full of entertainments from start to finish, with lots of people going to and fro, profuse and lavish decorations and a general air of festivity. The majority of them say so, and further proof is added by the eagerness displayed by some fond mothers of the Borough to get their children or relatives in for Christmas, however healthy they may be.

Concerts will be dealt with in detail elsewhere; here some account will be given of the decorations in the wards; detailed criticism of the minute attractions of each ward, such as the chronicling of the fact that in one ward the fireplace was decorated with festoons of ivy,

while in the rival ward the same part of the architecture was adorned with pink art muslin, has very little interest for any but the immediate elaborators of each small scheme, and is therefore unnecessary.

We noted with great pleasure that in nearly every ward a marked reaction was apparent against the heavy and over-elaborate decorations of a few years back. The crowding of every nook and corner with thick bunches and ropes of holly, laurel and ivy, has given way to a much more artistic method of festooning to a moderate degree with well-knit but slender strings of ground ivy. This, combined with the modern appliances of electric light, gave the new wards the advantage. There is no doubt that of the surgical wards this year LYDIA was far and away the best, principally for the above reasons. The decorations were artistically arranged and not too crowded, and the electric light made the whole ward exceedingly effective when lit up. ASTLEY COOPER was better done than it has been for years, and CORNELIUS again reaped the advantage of clean walls and electric light.

In MARTHA, efforts at patriotic display were more apparent than actual artistic decoration, for, when all is said and done, a map of Africa is not an attractive thing. The sentiments of the ward were, however, admirable.

SAMARITAN, from innate architectural possibilities, always looks well, and its good points had been made the most of. It was a striking example of the unsuitability of fairy lights for ward decoration from the point of view of public convenience. The fairy lights look most most effective and are safer than Chinese lanterns, but they are so terribly liable to crack and spill their liquid contents. During the Samaritan concert there was a continual cannonade of dropping, deadly fairy lights, owing to the unavoidable draughts. There is no doubt that with the advent of electric light the days of the fairy lamps are numbered.

All the other surgical wards were well up to the average, and, as said above, uniformly showed a much more artistic conception of decoration with trailing green stuff than has been the case heretofore. The medical wards were very effective this year. Dr. Taylor's division of MARY was undoubtedly the best in the day time, the arrangement of the festoons being most striking. Dr. Perry's division was the more effective, however, when lit up, so honours were divided.

In PHILIP and STEPHEN the traditional and only possible method of decoration was carried out with no small success; the medical wards, from their greater height, always looking better than the surgical wards. The lanterns and festoons do not get so in the way of one's eyes.

At all concerts the most striking things in the way of decoration are the Sisters' tables. There is no more certain object of praise at any concert in any ward than the tables. Always most tastefully arranged, they lend an air to any ward, and are striking witnesses to the pride and interest taken in the Christmas work by the nursing staff.

PHILIP CONCERT.

The Philip concert was held this year on Boxing-day at 4·30 p.m., under the management of Mr. E. W. S. Rowland. The earliest of all the concerts and the pioneer of this season's fashions, it was excellent in all respects, especially in the fact that songs were chose to suit the patients' tastes, familiar and well tried, popular songs. The programme opened with a piano solo by Mr. J. G. Taylor, the best pianist at Guy's now that Mr. W. R. Cazenove has left, and following this Mr. H. Parrott sang "The Absent Minded Beggar," his never-failing "piéce de resistance" this winter. Whatever may be one's opinion on the artistic merits of the song, its sentiments are beyond reproach, and its ubiquity gives it somewhat the character of a national anthem. Miss Wylie sang "The Sheperdess" with great success, and was followed by Mr. T. Evans, a very fine singer, who gave "The Wonders of the Deep." Mr. Fitz-Hugh sang a comic song, and then Miss Maud Hoffmann scored the success of the evening with "At the Opera," a most artistic piece of work. Miss Agnes Davies sang "A May Morning," and the first part of the programme closed with a song, "The King's Own," by Miss Dresser. After the customary interval for tea and talk, Miss Stanton played a violin solo and Mr. Fitz-Hugh sang another comic song. Miss Maud Hoffmann again scored success in another recitation, followed by Miss Dresser in that ever popular song "Tatters." Miss Dora Wilson recited and Miss Agnes Davies sang "The Dear Homeland." After a comic recitation by Mr. Arthur Miller, Guy's only "Arthur," a most successful programme was concluded by Mr. T. Evans, who sang "The Village Blacksmith." In conclusion, we can only most heartily thank those ladies and gentlemen who came down to help by singing or otherwise, and by their efforts made Christmas brighter for those who are unfortunate enough to have to spend it in a hospital.

STEPHEN CONCERT.

A most successful concert was given in Stephen on Wednesday, December 27th, at 5 p.m. The ward looked exceedingly well; there was a large and appreciative audience, and additional interest was lent to the proceedings by the fact that it was practically Sister Stephen's last day at the hospital previous to her departure for South Africa. The programme opened with an excellent quartette, for piano and strings, by the Misses Linton, four talented young ladies whom we should like to listen to again. Good concerted music, especially up to the standard of this performance, is too rare to be missed, and we are glad that chance directed our footsteps to Stephen on that particular occasion. The ever popular and hard working Mr. Parrott sang "The Deathless Army," and was followed by Miss Dresser, who sang, "The Amorous Goldfish," from "The Geisha." Mr. Creagh Henry gave an excellent recitation, but hardly met with the reception that he deserved, as many of his points were missed by the patients, and his was really an excellent piece of humorous work. Two of the

Misses Linton again played on the violin and 'cello, and Mise Noel sang, "Only a Withered Rose," with much taste and amid great applause. The first part of the programme closed with a performance of Cowen's "Promise of Life," on the handbells, by Mr. Hopkins, who in response to rapturous applause had to give an encore. The second part of the programme was again opened by the Misses Linton, who played Gounod's "Meditation on the 1st Prelude of Bach," and as an encore an arrangement for piano and strings of "L'Extase," by Francois Thomé. Mr. Parrott sang, "Long ago in Alcala," and then Miss McQuoid, the fortunate possessor of a beautiful contralto voice, sang "Beloved, it is Morn," which met with a great reception. Miss McQuoid also sang again later in the concert. A recitation by Mr. A. A. Miller, a musical sketch by Mr. Creagh Henry, and a great performance of "The Holy City," on the handbells, by Mr. Hopkins, followed by "Auld Lang Syne," and "God Save the Queen," on the same popular instruments, brought a good concert to a most successful conclusion.

LAZARUS CONCERT.

Wednesday, December 27th, was the date on which Sister Lazarus gave her annual concert, and although the same date had been appropriatied by several other wards, the attendance in Lazarus was very good indeed, and quite in keeping with the excellent programme. It is most difficult when all the performers are distinctly above the average, to call attention to any one performer or any one performance. To have one's musical sense pleasantly stimulated by every item of a long evening, is in itself a sufficiently rare occurrence to deserve mention. At the same time, however, it prevents any one performer from creating that impression which would necessarily follow the same performance in less excellent surroundings. Viewing the concert, however, from the point of view of a lover of instrumental music, the violin duets of the Misses Toms were magnificent, both in technique end interpretation. Mr. Pimm showed considerable skill in the management of a most difficult instrument, but his choice of studies was perhaps not of the happiest. It still remains true that the majority of Englishmen fail to understand Wagner. The vocalists were a distinct success. Such old favourites as Messrs. Hicks and Mullins, were assured a hearty reception before their appearance, the others evoked enthusiasm by their own merit.

Programme:—Violin duet, Concerto, Misses Toms; song, Beloved it is Morn, Miss Spain; song, The Admiral's Broom, Mr. L. Walker; song, The Promise of Life, Miss Jerrard (Savoy Theatre); recitation, Professor Terry O'Mulligan, Mr. Stacey Aumonier; song, The Swallows, Miss Lee; mandoline duet, Toccatina, Messrs. Edwards and Clark; song, A May Morning, Miss Jerrard; clarionet solo, Lohengrin, Mr. Pimm; song, A Dedication, encore, Come to me in my dreams, Mr. H. T. Hicks; violin solo, Meditation, Miss Toms; song, Leaving yet Loving, encore, Dreamy June, Miss Spain; recitation, The Wreck of the S.S. Puffin, encore, Modern Novel, Mr. Stacey Aumonier; clarionet solo, Chopin, Mr. Pimm; song, Husheen, encore, Killarney, Miss Lee; song, The Bandolero, Mr. Walker; song, Miss Walker; song, Kaffir Love Song, encore, A Chestnut, Mr. Mullins; violin duet, Auld Lang Syne, God Save the Queen, Misses Toms.

QUEEN CONCERT.

This concert was held on Friday, December 29th. We could wish that Mrs. Shaw and the Misses Shaw would come down to Guy's every evening and whistle to us: certainly if they did there would be a large number of men wanting to learn to whistle, a thing few know how to do. Certainly the success of the evening was scored by these ladies, and they were encored raptuously every time they stepped upon the platform. The programme was opened by a piano solo by Mr. J. G. Taylor, followed by Mr. Parrott, who sang "The Bandolero." Mr. Soper played a violin solo excellently, and then Miss Kimball sang "The Promise of Life." Miss Daisy King was heard to great advantage in "A Gipsy Maiden," and Miss Mabel Hume made a great success of "When the little pigs begin to fly," especially with a topical verse on the Transvaal war. To end the first part, Mrs. Shaw and her daughters, as remarked above, made an enormous hit with their whistling. In the second part, most of the performers sang again, and in addition Mr. Fitz-Hugh and Mr. Segreda both took their audience in their respective popular styles. It cannot be too strongly impressed upon all the ladies who came to help at the concert how much their services are admired and appreciated. A few words with the patients afterwards would fully convince them of the latter's gratitude.

SAMARITAN CONCERT.

Last, but not least, in fact the most successful of the year, Samaritan concert brought the Christmas week to a most brilliant conclusion on Saturday evening last. The chief credit of the evening is due to Mr. A. A. Miller, who was responsible for a most amazing galaxy of talent, among them many old friends of the Smoking concert, to wit, Messrs. Mark Hyam, Davey, Stanley Grahame, Wilson James. The programme opened with a piano solo, "Au Courant" (Godard), by Miss Madge Miller, who was followed by Mr. Davey, the possessor of a most musical and well-trained voice. Mr. and Mrs. Dam then sang a most excellent duet, one of the best pieces of concerted singing which we have had the privilege of listening to for a long time, and it is a thousand pities that they had not time to sing again. For artistic finish it was by far the best item in an exceptional programme. Miss Lily Hyslop then sang "In different circumstances" with great success, and Mr. Grimwood gave an excellent recitation. A song by Mr. Tate, comic songs by Messrs. Stanley Grahame, and another recitation by Mr. Mark Hyam followed, and still more artistes appeared. Miss Dommett sang a most difficult and effective air by Meyerbeer. Mr. Soper played the violin, and the first

part of the programme was finished amid uproarious applause by Mr. Wilson James. As there were no printed programmes, the exact names of many of the songs have escaped our memory. Not so the memory of their enthusiastic reception. After a brief interval for tea, though it was 7.30 p.m., and undeterred by the danger of continually exploding deadly fairy lights, all the performers sang or played again, and it was just nine o'clock when "God save the Queen" brought by far the best concert of the year to a most successful close.

THE OUT-PATIENT TEA.

For the third successive year this function was duly carried out, and proved a great success. Over fiv hundred and fifty children attended on the last occasion, and were regaled with the usual "feed," followed by a demonstration by the Christmas Nigger Troupe and a Punch and Judy performance, and the afternoon's entertainment was brought to a conclusion by Christmas trees and the presentation of a parcel and a garment to each child. The affair was carried out much on the same lines as the previous occasion, while one markedly successful innovation was introduced. This consisted in keeping the boys at one end of the hall and the girls at the other for the whole of the afternoon, thus avoiding that amount of confusion which necessarily arose when all were packed into one half of the hall. This, of course, necessitated the duplication of both Punch and Judy Show and Nigger performance, but the whole arrangement worked very well, and the extra expense was fully justified. The children appeared to fully enjoy themselves, and appreciate the good things provided for them, and if noise is any criterion of their feelings, then it is certain that they were happy for at least one afternoon of their lives.

An erroneous statement has crept into the papers that the whole expense of the Out-patient tea is borne by the students. This is certainly not so. The Governors and Staff have helped most liberally, and above all, to the nurses and sisters is due by far the greater share of credit of the success of the whole affair. They have been indefatigable in their efforts, and the greater part of the collecting of money and garments, and a large share of the actual work on the day, was done by them. It is only to be regretted that so many of them who so kindly helped were not allowed to witness the enjoyment of the children. Last Christmas many of the probationers as well as head nurses were given permission to be present, but this time the probationers were refused it, much to their regret. Doubtless there was some good reason, but it certainly was not an obvious one. Below is appended a list of donors of garments, etc. It is intended in next issue to publish full list of subscribers to the fund.

LIST OF DONORS OF CLOTHES, TOYS, &c.:—Mrs. Fredk. Taylor, Nurse Field, Mrs. Landon, Nurse Stanyon, Nurse Heygate, Nurse Bryan, Nurse Allen, Nurse Brown, Nurse Reed, Nurse Daniell, Nurse Candy, Nurse L. Collins, Sister Martha, Sister Charity, Nurse Densham, Mrs. Duck, Mrs. Hale White, Miss Smith, Miss Graham, Nurse Haughton, Nurse Ransford, Mrs. Ward, Nurse Moore, Nurse Anners, Mrs. Hodgson, Misses Morris, Mrs. E. F. Walker, Mrs. F. I. Walker, Mrs. E. B. Parry, Mrs. Heazell, Mrs. Cock, Mr. Lafone, Miss Dupins, Miss Irwin, G. Hambro, Esq. (trees), Walter Palmer, Esq. (biscuits), Henry Lafone, Esq. (100 lbs. tea), James Southwell, Esq. (500 pkts. sweets), Nurse Garnett, Nurse Jackson, Mrs. Stewart, and many others.

NEW YEAR'S EVE.

THOUGH it was Sunday evening a large number of men turned up on New Year's Eve to welcome in the new year in the traditional manner at Guy's. A fine evening and a lavish decoration of Guy's statue promised so well that a large crowd of the Borough population assembled before the gates, and shortly before twelve broke into the quadrangle, whence they were with some difficulty forcibly evicted. On the stroke of twelve, "Auld Lang Syne" was started, the President of the Residents beating time from the base of Guy's statue with a lighted torch. As the gentleman who started the chorus was evidently a high soprano, the effect was disastrous, and most men could not reach the high notes. Nobody cared, however, and the time-honoured chant finished with a race round the statue. Cheers were given for the Queen, the Prince of Wales, the Army, Mr. Bonsor and Thomas Guy, and the ring broke up into enthusiastic knots of men chairing popular residents shoulder high round the quadrangle. As Dr. Perry was away his house was not serenaded, but Mr. Fripp was pulled out of bed to drink the new year in; and 1900 was ushered in as cheerfully as usual over in the College.

In Lighter Vein.

Christmas has come and gone (thank the Lord) and we are now comfortably into 1900. I don't know if that is tidings of great joy to you, but to me Christmas is always a good thing over. For my Peace on Earth is always disturbed by the din of bones and tambourines and phunniphones (with this year the added horrors of a concertina and a drum), and Goodwill towards Men, for me, means paying out gratuities to those who earn respectable salaries, whilst I am earning none.

I believe there are people who think that the Niggers (whom an unknown miscreant once christened "Disguysed") thoroughly enjoy themselves; indeed, I have heard one in high authority say as much. Well I have tried it a few times, and up to now I have failed to discover the enjoyment of covering your face and half your hair with filth which no power on

earth can move in less than half an hour, nor have I found out the supreme ecstacy of singing songs for six and a half mortal hours to audiences who receive you in tolerant silence.

I am told that the patients like to see their doctors dressed up, and such of them who are strong enough to push their way through the crowd of visitors, doubtless do. I should think the proportion of children who are frightened to those who are amused is about even. When I was a child I was fond of listening to niggers, and would follow them in the streets when I could evade the watchful eye of my guardians; but now I have put off childish things, and I know the secret of their inner lives. I never laugh at them now, there is seldom anything to laugh at, but I pity. No nigger on the sands ever appeals to me for alms in vain; I always drop a penny in his little tambourine even if I have to go without my lunch for it. And yet the professional "busker" is better off than the Disguysed (ugh!) Minstrel, for he at least can sleep in his "make-up."

And if you don't appreciate the efforts of the Christmas niggers after that you ought to.

I did not see much of the ward concerts this year, but I am told that they reached the usual level. The professional concert seems to be a thing of the past, but many members of the theatrical profession very generously came down and mingled with the amateurs, and their services were greatly appreciated. It seems ungracious to look a gift-horse in the mouth, but I cannot help thinking that it is a pity that one well-known and justly popular entertainer did not modify his wheezes and songs for hospital consumption. He probably argued that the patients liked their low comedy highly coloured, and as the concerts were given to them, the rest could go to blazes. But he should remember that the nurses form no small proportion of the audience and are entitled to consideration. Besides it is very awkward to be caught sniggering when you ought to be looking down your nose.

I was informed by a perfectly unprejudiced person that the Luke concert was the best ever given at Guy's. This is very likely true, but I only saw a small portion of it. When I looked in I found a large crowd, amongst which my informant was jostlin'. Nobody sang "The Swanee River." I wonder why not. Perhaps they were afraid of getting "the goose." A.

Guy's Hospital Dental Society.

A MEETING of this Society was held on November 21st, Mr. Baker, the President, occupying the chair. The last minutes having been read and agreed to, Messrs. G. H. Morris and J. Milligan, as respectively representing their entries, were elected on the committee; the casual communications were then called for.

Mr. ROWLETT showed models of the mouths of twins each having the same irregularity.

The Secretary then showed for the following gentlemen who were not present;—

Mr. HAYES PALMER.–Models showing "Suppression of Permanent Teeth" in a patient eighteen years of age. There was no history of further dermal peculiarity.

Mr. P. GREENWOOD.—"A Lower Partial Denture" removed from the mouth as a solid block of tartar, having been worn continuously seven years; considerable absorption of the gum had taken place.

Mr. F. MORRIS.—"Abnormalities." A three-rooted second upper tricuspid; an upper molar with deflected roots; and a left upper incisor showing exostosis caries and absorption in its root.

Mr. WHITCOMB.—"Abnormalities." A double-rooted lower canine.

The President then called on Mr. LOWE for his paper on

PLASTER IMPRESSIONS.

MR. PRESIDENT AND GENTLEMEN,—Although my subject is of a less noble character than that of the able paper of last meeting, it may be one not without interest to those students who have given any attention to it.

There is a vast amount of scepticism about the advantages of plaster as an impression material, yet I feel sure that there are many here who are quite as anxious as I am to have a correct opinion on the subject, unbiassed by any difficulty experienced in manipulation. I shall therefore, at the outset, mention some of the chief points to be aimed at in the acquisition of a satisfactory impression, whatever material be employed, and showing how these requirements are met with through the medium of our material in consideration, go on to a few remarks about methods which have given me satisfactory results.

Five chief points to be aimed at may be briefly enumerated as follows:—

1. The accuracy of the impression.
2. A minimum force necessary to press the material into position so that soft tissues be not displaced.
3. Moderation of temperature of material so that any tender surfaces be not pained.
4. Ease of manipulation in mouth.
5. Ease of obtaining a perfect model from the impression.

Of these five requirements, a very few words will suffice to show that the three first are not merely fulfilled, but meet their highest perfection in the use of plaster of Paris as the impression material.

The accuracy of a plaster impression is established on three bases:—

a. The extreme plasticity of the batter state in which it is inserted, thus assuring the closest adaption to the surface it comes in contact with.

b. Its unyieldingness when once set, rendering it more ready to fracture than drag, when withdrawn from an undercut position.

c. Its final solidification, unalterable by temperature, so that subsequent impression is impossible. To these facts is due that sharpness and fineness of the rugae, frænum, and other folds of the mucous membrane which so readily distinguishes a cast of a plaster impression from one taken in Stent, wax, gutta percha.

Of the second requirement nothing further need be said than since the plaster is applied in a creamy consistency, the softest tissues will not yield to the small amount of pressure exerted in carrying it into place.

Point three, namely, moderation of temperature, is also fulfilled to entire satisfaction. For since the water used in mixing should be of about 150° F., the warmth of the batter will soothe rather than excite an inflamed or tender surface. And even should there be no such surface, there are repeated instances where a sensitive palate is quite scalded by composition or gutta percha at 195°.

Since I am sure that these facts will be admitted as correct, and consequently the first three requirements of an impression material have been most faithfully fulfilled in the use of plaster of Paris, it will be to the practice of points 4 and 5, namely, to the manipulation, both in taking the impression of the mouth, and to the production of the cast from that impression, that I purpose to draw your attention this evening.

As it is not my intention to show how, on account of their different capabilities and properties, one impression material is to be preferred to another in meeting the requirements of a special case, but rather to devote myself to a description of the manipulation of plaster of Paris in general, I shall assume that we have an imaginary case before us of which we are going to take plaster impressions.

There are several preparations of plaster for impression purposes, of which Ash's superfine, and Teague's compound take first place. Of these two I prefer Teague's plaster for the following reasons. Since it is of a pinkish colour the impression is very readily distinguished from the white plaster of the cast; owing to a peculiar oiliness or glaze when set, and to a grit in its composition, it does not so readily adhere to teeth standing in the jaws; and its fracture is more ready. Again, it is not so apt to enclose air bubbles, and further, when set, and cast, it is not so dense as the plaster ordinarily used for casting, and thus separation is facilitated. These properties therefore render it especially useful in partial cases.

Let us suppose that our case before us is an edentulous one, for in such plaster is used to its greatest advantage. Indeed, where only a few of the series are missing, plaster of Paris should certainly give place to modelling compositions, since its main beauty comes out when dealing with soft tissues.

Since the plaster when once mixed sets rapidly, the operator should make thorough preparations before mixing. Such will be to seat the patient in an upright position, and so that the head may be brought moderately forward when necessary; place a napkin beneath the chin, and have a glass of water and a mouth mirror handy.

A suitable tray having been selected, the plaster may be mixed at the chair side. To hasten setting, the water may be about 150° F., and with the addition of a pinch of salt. If white plaster be used some colouring material should be added, such as a few drops of red ink, or a grain or two of vermilion. The plaster being added it is stirred until it is sufficiently set to draw up in a peak after the spoon.

In the case of an upper impression it is a good plan to mix the plaster quite thin and wait until it has sufficiently set to allow of its packing.

The plaster should be heaped up well into the middle of the tray, and art lies in the nice judgment of the quantity put in, since too much is as great an evil as too little.

Keep the handle of the tray slightly tilted downwards while carrying to the mouth. Good advice at this stage is "be deliberate," because the success of the impression is almost entirely decided by its insertion and consequently great pains should be taken at this point.

Introduce the tray by the right heel, then with the second finger of the left hand pull out the cheek of the left side sufficiently to allow the left heel to enter. The tray being now within the mouth, carry both heels well back to the condyles. With a shaking movement raise the handle of tray, noting carefully to get it in the median line, and allow the air every chance to escape from the vault of the palate; with the finger and thumb stretch the upper lip upwards and outwards so that the anterior aspect of the ridge be unencumbered by muscles or mucous folds. The tray must finally be pushed right up into place round the condyles, and may be comfortably supported in position by the second finger of the left hand in the palate.

If any surplus plaster should have happened to run down towards the throat and irritate the soft palate, a mouth mirror makes a convenient spoon for its removal, and the patient should be directed to incline the head forwards. After about three minutes the plaster is sufficiently set to be withdrawn.

According to Mr. Wynne Rouw, whom we have heard lecture on the subject, the supreme moment for withdrawal is at the first generation of heat; but as that moment is difficult to ascertain, since the plaster is generally mixed with warm water, a more practical test is resorted to, namely, as soon as the plaster remaining in the bowl will break with a short fracture.

The main object in withdrawing an upper impression is to destroy the suction, which in most cases is very

considerable. This is best done by rocking the tray from behind forwards, while instructing the patient to cough. Such persuasion will, in most cases, be sufficient to bring the tray away. It will be sometimes found that the patient involuntarily slightly closes the mouth, bringing the heel of the tray against the lower condyles; therefore, if the impression seems to hang after primary loosening, notice should be taken lest it is so caused.

Occasionally, cases present themselves when the impression remains immovable after all such efforts, and then the tray must be broken away from the plaster, and three deep incisions made along the ridge. A lateral one on each side along the molar and bicuspid region, and one transversely in the anterior part.

This will allow the plaster to be broken away in four pieces, two buccal, one anterior, and one palatal, all of which may be exactly fitted together in the tray, and waxed there as would be any other fracture.

This method, which may appear ugly to those who have never seen it practised, is, in fact, advocated as a general practice by Dr. Teague, the inventor of the preparation of the plaster of that name.

In every case, as soon as the impression is withdrawn, examination should immediately be made, and if there be fracture of any requisite part it should be secured before the patient be allowed to wrinse the mouth.

It might here be added that, should the impression not give satisfaction, and the operator desires to make a second attempt, he should make it at once rather than wait till the patient's next visit. For it will generally be found that one is rather more at home with the mouth on second acquaintance, while if some time elapses between the attempts, that benefit will be lost. Again, it will often be found that the patient is inclined to believe that the failure is greatly due to some fault on his part, and now, knowing what is expected of him, will rather be through with an unpleasant operation while he is at it.

In cases of nausea, or extreme irritation of the soft palate, good results may be obtained by spraying with 4 per cent. solution of cocaine, or gargling with cold or camphor water, but better still by the precaution of a dose of bromine about an hour beforehand.

For an impression of the lower jaw the plaster should be mixed rather thicker, for in the first place it is desirable that the plaster should not run out when the tray is turned over, and as there is little danger of enclosing air bubbles, while further there is the tongue and saliva to contend with, the sooner the plaster sets the better.

The tray may also be filled a little fuller, for moderate surplus will here give strength without choking the patient, and the plaster extending backwards to the condyles, which are not always included by the tray, will secure a good impression of them.

When inserting the tray, great deliberation of action gives the best results. As in the upper, it should be inserted by one heel at a time, and carried well back, until the alveolar ridge is directly subjacent to the corresponding part of the tray. Then distend the right cheek outwards with a finger passed backwards along the ridge, and depress the tray on that side. The other side should be treated similarly, and thus all danger of including a part of the loose tissue of the cheek is avoided. Even pressure is then distributed over the whole tray, so that a sufficiently deep impression is obtained. All this takes a long while to describe in words, but in practice it takes but a moment or two to give individual attention to each successive step, the observance of which can hardly fail to give a very satisfactory result.

In the large majority of cases, very little difficulty is met with in removing a lower impression. The tray should be rocked from side to side and then tilted up at the condyles. Since the only likely undercut is found in the incisive region, and that part is invariably well supported by the tray, fracture seldom occurs, except quite posteriorly. All fractures should be at once put in position and maintained there with a little sticky wax.

With regard to the next step, treating the surface of the impression, it may be said that the object is, to so render it, that there may be the least possible adhesion between it and the subsequent cast, and that the two may be easily distinguished between. Consequently if the impression be white, it should be coloured, red ink or carmine answering very well, or some colouring matter be added to the separating medium.

Some men use various varnishes which are sufficiently coloured in themselves, others use soaps, oils, &c., indeed, there are so many excellent and ingenious ideas concerning this treatment that I shall confine myself to my own.

A sufficient quantity of Hudson's dry soap powder is dissolved in about a pint of water, to make, when cold, a jelly which takes but very little to liquidize again. This is kept in a convenient large-mouthed vessel which may be quickly heated, and into the liquid soap solution the impression is plunged. If dry the plaster will absorb a good deal of the solution into its substance, and when after a minute or two, the impression is taken out, the excess is quickly drained and blown off. Thus the surface is subjected to absolutely no friction, and the most delicate processes are preserved. This process of soaking has still further advantages, for it is automatic, and affords a minimum chance of those vexatious air bubbles which occur so plentifully in the lathering method.

Also, owing to the incorporation of soap, the molecular cohesion of the plaster is in a great measure destroyed, so that its subsequent removal is greatly facilitated.

Our impression is now efficiently soaped, and pins inserted to strengthen any teeth present, so let us proceed to cast it. The surface of the impression must be damped, and thinly mixed plaster flowed over it. Great care must be taken to get it well down into marked depressions, and this is assisted by blowing and gentle tapping. More and more plaster is added and the model built up in the ordinary way.

In about half an hour the model is generally set and hard enough for separation from the impression. It will be found that separation is greatly simplified by a minute or two's boiling. By boiling, the plaster expands, and since that of the impression has been set longer than that of the cast the individual expansions do not take place simultaneously. Also the boiling water combining with the soap solution in the impression plaster renders it very soft and crumbly. Care must be taken not to soften the model by overboiling it. All that is required is to thoroughly warm the plaster through, and the little boiling which suffices to do that is not enough to deteriorate the model.

After the tray has been removed the impression is tapped with a small hammer in the palate and around the ridge so far as it is strong enough. It will soon be seen to loosen from the cast, and with a little judicious use of a knife combined with that of the hammer the whole is shortly removed. Sometimes it happens intact, more often, however, piece by piece.

Supposing that a tooth or other delicate process has been broken off, it may be firmly secured in its place with a little very liquid "osteo." The model is then trimmed up, dried, and dipped or not dipped in stearine as desired.

The beautiful process of swaging foil into the impression, prior to casting, I have not mentioned, not because I for a moment condemn it, but rather because my several attempts to effect it ended in such disheartening failures, that for the present I have abandoned the idea, and object even to refer to them again. I have no doubt, however, that there are gentlemen here to-night who are quite at home with the process, and who will perhaps favour us on some future occasion by treating on it.

As I conclude I want to thank gentlemen for their kind and sympathetic attention to a treatise, of whose weaknesses I am only too well aware, and ask them to reserve their judgment on the use of plaster of Paris as an impression medium until they have given it a fair trial, and found for themselves whether or no it repays all the pains and attention that can be given to its manipulation.

A discussion followed, and Mr. Lowe's exhibits of an impression with Dr. Teague's plaster, and two models of the same mouth, one from a plaster impression and one from the ordinary Stent's composition were looked at. Some of the points discussed were the composition of Dr. Teague's plaster; the management of undercuts; and a criticism of the way in which Mr. Lowe used the word "condyle"; it was accepted that the tuberosity of the maxilla was intended. A vote of thanks for the excellent paper was then passed, and the next meeting having been published, the proceedings terminated.

Mr. ROBERT CUFF, M.B. Lond., M.R.C.S. Eng., has been appointed a magistrate for the Borough of Scarborough.

Pass List.

University of London, 1899.

M.D. EXAMINATION.

R. H. Ashwin, H. W. Bruce, A. J. Cleveland, C. R. Hodgson, R. W. Mayston, H. J. Starling.

M.S. EXAMINATION.

W. S. Handley. W. T. Milton.

B.S. EXAMINATION.

FIRST DIVISION.—P. Turner.

SECOND DIVISION.—A. H. Carter, C. T. Hilton, J. Howell, G. N. Meachen, W. G. Stewart.

University of Cambridge, Michaelmas Term, 1899.

THIRD EXAMINATION FOR THE MEDICAL AND SURGICAL DEGREES.

PART 1.—A. H. Davies, C. H. Glenn, J. A. Glover, T. E. Holmes.

PART II.—A. C. Fry, F. Shufflebotham, D. P. Watson.

FIRST EXAMINATION.

PART II.—ELEMENTARY BIOLOGY.—B. H. Stewart.

School Examinations, December, 1899.

ELEMENTARY ANATOMY.

F. Barnes, R. Franklin, H. B. German, F. G. Goble, A. E. F. Kyraston, G. C. Lowe, E. C. Peers, J. F. Rey.

HISTOLOGY.

L. Cooke, R. Franklin, J. J. Gardiner, F. G. Goble, E. H. Griffin, G. Nunn, C. A. E. Ring.

PRELIMINARY SCIENTIFIC STUDENTS.

CHRISTMAS EXAMINATIONS.

BIOLOGY.

Over three-quarters.—F. M. Longson,

Two-thirds and upwards.—H. A. Watney, E. L. Norton, A. B. O'Brien, E. M. Harrison, T. H. Barton, E. C. Lowe, F. T. H. Wood.

Half and upwards.—A. G. Jones, W. P. Purdom, E. F. Milton, R. J. Bentley, E. Bellingham-Smith.

One-third and upwards.—H. S. Knight, T. C. Pocock, E. H. Adams, T. Turner, P. D. F. Magowan, F. A. Sharpe, J. T. Smalley.

Less than One-third.—G. N. Bartlett, G. H. Teall, S. C. Brown, R. G. Oram, F. Morres, J. E. Hodson.

CHEMISTRY.

DIVISION I.—H. S. Knight, 82, F. T. H. Wood, 78, T. Turner, 67.

DIVISION II.—E. H. Adams, 65, F. A. Sharpe, 62, F. M. Longson, 60, E. Bellingham Smith, 55, T. C. Pocock, 55, J. E. Hodson, 52, H. A. Watney, 52, E. F. Milton, 50.

DIVISION III.—E. M. Harrison, 47, T. H. Barton, 45, G. N. Bartlett, 40, A. G. Jones, 40, E. C. Lowe, 40, P. D. F. Magowan, 40.

DIVISION IV.—S. C. Brown, 32, J. T. Smalley, 28, A. V. Maybury, 21, R. G. Oram, 0.

PHYSICS.

DIVISION I.—H. S. Knight, 81, E. H. Adams, 76, T. Turner, 75, F. T. H. Wood, 73, F. M. Longson, 72, T. H. Barton, 72, H. A. Watney, 70.

DIVISION II.—E. M. Harrison, 66, G. N. Bartlett, 64, J. E. Hodson, 64, T. C. Pocock, 64, A. G. Jones, 63, P. D. F. Magowan, 54, E. F. Milton, 51.

DIVISION III.—E. Bellingham Smith, 49, F. A. Sharpe, 49, S. C. Brown, 45, J. T. Smalley, 40.

DIVISION IV.—E. C. Lowe, 18, A. V. Maybury, 9, R. G. Oram, 0.

SECOND YEAR'S TEST EXAMINATIONS.

PHYSIOLOGY.

(Maximum marks, 500.)

P. R. Bolus, 380, P. A. Peall, 330, H. S. Brown, 320, A. M. Webber, 320, K. Black, 320, R. Larkin, 310, G. Carlisle, 250, L. S. H. Glanville, 230, S. C. Bowle, 230, W. F. Box, 230, H. Watts, 220, E. J. Gaffney, 220, F. W Fawssett, 180, H. D. Smart, 170, G. F. Hardy, 170, H. C. Winckworth, 160, C. E. Iredell, 160, G. L. Buckeridge, 160, R. G. Anderson, 150, C. R. Shattock, 120, J. F. Rey, 110, D. H. Richards, 100.

ANATOMY.

(Maximum marks, 150.)

G. Carlisle, 112, H. S. Brown, 107, K. Black, 101, R. Larkin, 93, D. H. Richards, 89, A. M. Webber, 88, W. F. Box, 87, C. D. Pye-Smith, 84, P. A. S. Dyson, 83, F. W. Fawssett, 83, W. L. M. Day, 83, H. C. Winckworth, 83, G. H. Rees, 81, L. S. H. Glanville, 81, B. Moiser, 79, P. A. Peall, 76, C. E. Iredell, 74, P. C. V. Bent, 72, R. E. Brayne, 72, G. L. Buckeridge, 70, C. F. Fraser, 70, S. C. Bowle, 68, H. Watts, 63, E. J. Gaffney, 60, W. W. Read, 59, C. R. Shattock, 58, H. D. Smart, 48, R. G. Anderson, 47, H. O. M. Beadnell, 47, W. S. Orton, 41.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee :—

Clinical Assistants. — Messrs. C. T. Hilton, W. G. Stewart, F. G. Cross, D. G. Greenfield, A. H. Davies, O. Marriott.

Clinical Assistants in Medical Out-Patients.—Messrs. A. Fraser (Dr. Shaw); W. H. Brailey (Dr. Washbourn); A. Densham (Dr. Bryant); T. E. Holman (Dr. Fawcett).

Clinical Assistant in the Aural Department.—Mr. C. H. Fagge.

Obstetric Dressers.—Messrs. J. Atkins, H. M. Reeve, E. F. Reeve, J. A. Wood (January 1st).

Clerks in the Eye Wards.—Messrs. E. J. Crew, A. Fraser (January 1st); W. H. Brailey (February 15th).

Dressers in the Throat Department.—Messrs. R. M. Barron, E. A. Miller, H. Braund, C. H. Glenn, R. C. Mullins, F. O. Stoehr.

Clerks in the Throat Department.—Messrs. A. Densham, G. B. S. Soper.

Assistant Surgeons' Dressers.—Messrs. H. C. Keates, J. F. Douse, W. M. Robson, A. Wylie (Mr. Jacobson); A. W. Soper, S. C. H. Bent, A. W. Gater, G. S. C. Hayes, G. B. S. Soper (Mr. Symonds); C. E. Gaitskell, T. H. F. Roberts, A. C. Nash, E. Roberts (Mr. Lane); A. Croneen, G. T. Collins, C. B. Penny, M. J. Rees, J. Evans (Mr. Dunn).

Medical Ward Clerks.—Messrs. G. Evans, D. H. Trail, F. C. Wetherell, G. T. Wrench, H. W. Brown, M. A. Collins, W. J. Davies, A. C. H. Gray, G. W. C. Hollist, R. C. Lawry, H. P. Wiltshire, J. A. Andrews, E. G. Allport, O. W. Richards, D. S. Graves, H. A. Cutler, G. B. F. Churchill, W. H. Bowen, M. Coplans, F. Richmond, M. W. Cohen, A. H. E. Wall, H. Barber, R. T. Collins, J. C. Curtis, C. H. Gask, J. W. Gromitt, G. F. Humphreys, T. G. Miles, G. Moir, W. G. Parker, W. A. G. Stevens, A. H. Turner, R. Willan, J. C. O. Bradbury, A. D. E. Kennard.

Assistant Physicians' Clerks.—Messrs. C. Tessier, S. Child (Dr. Shaw); E. J. Crew, H. J. Gater (Dr. Washbourn); L. J. Hughes, G. H. H. Manfield (Dr. Bryant); E. Bigg, A. D. E. Kennard (Dr. Fawcett).

Surgical Ward Clerks.—Messrs. C. E. Bartlett, F. L. Thomas, W. H. Cole, N. N. A. Houghton, W. W. C. Jones, W. C. Lewis, A. E. H. Pakes, C. J. Pinching, P. N. B. Odgers, F. H. Parker, A. J. Urquhart.

Clerks in the Skin Department.—Messrs. J. A. Andrews C. H. Glenn.

Dental Surgeons' Dressers.—Messrs. E. Cohen (January–February); T. H. Body (February–March); H. A. Higgens (March–April).

Aural Surgeon's Dressers.—Messrs. R. C. Mullins, T. E. Holmes, E. A. Longhurst (January–February); H. Braund (March–April).

Assistant Surgeons' Clerk.—Mr. K. Anderson (Mr. Jacobson).

Post-Mortem Clerks.—Messrs. T. P. Thomas (January–February); C. H. Glenn, P. S. Mandy (February–March).

Nursing News.

MATRON'S OFFICE.

Sister Stephen (Miss Creighton) left us on Monday (January 1st), and starts for South Africa this morning to take charge of the hospital train sent out by H.R.H. Princess Christian.

Sister Patience (Miss C. R. Jones) has been transferred from Patience to Stephen ward, and Nurse L. V.

Haughton, head nurse in Mary ward, who has just completed her three years' training, has been appointed Probationary Sister in Patience ward.

Miss E. S. Hodges has been appointed Assistant Matron, and will commence her new duties on March 25th. Miss Hodges entered the hospital over ten years ago, and has filled the posts of Sister of the Out-patient Department, Night Sister, and is at the present time Sister of Mary ward. Mrs. Gibbins, who took the Assistant Matron's duties in the summer, is acting as the Assistant Matron *pro. tem.*

Miss Margaret Traill, who entered the hospital in August, 1893, has been appointed Sister of Mary ward. Miss Traill was head nurse in Mary ward for over two years, and left in 1896, returning as Sister of Victoria ward in November, 1898.

Nurse J. Gray has been appointed Probationary Night Sister, to fill the vacancy caused by the departure of Sister Lilian (Miss Tippetts) for South Africa, and will probably take up her new duties in a fortnight's time. Miss Gray entered the hospital in November, 1895, and is Staff Nurse in Philip ward.

Nurse Haydon, head nurse in Astley Cooper ward having completed her three years' training, left on December 23rd to take up work on the Private Nursing Staff.

Nurse Martyn, head nurse in the Isolation ward, has been transferred to Astley Cooper, and Probationer Pegler has been appointed Head Nurse in the Isolation ward.

Nurse E. Collins, head nurse in Queen ward, having completed her three years' training, left on December 30th to take up an appointment as Sister at the Sussex County Hospital, Brighton, and Probationer Brooker has been appointed Head Nurse in Queen ward.

Nurse Jackson, head nurse in Charity ward, having completed her three years' training, left the hospital on January 1st to join the Private Nursing Staff, and Probationer Drever has been appointed Head Nurse in Charity ward.

Probationer Orr has been appointed Head Nurse in Bright ward, and succeeds Nurse Hockley, Staff Nurse, who is shortly entering upon her midwifery training.

Probationer Carey succeeds Nurse Haughton as Head Nurse in Mary ward.

It is to be regretted that a great many of the Nursing Staff are off duty owing to the prevailing influenza.

The Extraction of Foreign Bodies.

ACCIDENTS inflicted, by means of which pieces of needles, steel, glass, etc., becomes embedded in the muscular and other tissues of the body are so common that I think a few words founded on experience in their extraction will not come amiss.

Lately one has come across many cases of this sort in which the foreign body, and I am speaking especially of needles, has not been extracted after the part has been carefully skiagraphed and the body localized; and one is constantly being told that the cause is due to an inaccurate localization, so throwing an aspersion either upon the value of the Rays or upon the capability or the skiagraphist. In the majority of these cases it is not the fault of either (never of the former), but is due to the operator, who is generally a dresser with but limited experience, operating in an unscientific manner and totally disregarding the precautions which one is constantly endeavouring to thrust upon him.

Within the past few weeks Mr. Shenton and I have had the opportunity of operating on about twenty cases of pieces of needles in the hands. Only in one of these was the needle not extracted, and in this case it was a small piece firmly wedged in between two bones of the carpus, and here we felt the "metallic click," but left the body in situ owing to the great difficulty of obtaining a firm hold on it with any form of forceps at our disposal, without doing unjustifiable damage to surrounding parts. In five or six of these cases lengthy operations had previously been performed by others with the same advantage as we had.

The most important points which should be observed in operating are the following.

1. *Cut at right angles or obliquely to the direction of the foreign body, and as near its middle as possible.* It is only quite lately that one has been able to dissuade men from incising in the direction of the long axis, and even now it is a common practice to proceed at once to cut in this direction if the substance be not at once found on cutting at right angles. I maintain that the only value of such an incision is to allow more room for exploration, and that it is rarely necessary. It is a common occurrence for a foreign body to be missed which is only a minute fraction of an inch from an incision in the same direction as itself, as a very small quantity of tissue between the probe or scalpel and the metallic substances quite obliterates the "metallic click" so valuable in making quite sure that one is striking the foreign body.

The common objection to cutting at right angles to the directions of the foreign body is that this often necessitates cutting also at right angles to tendons, vessels, etc., but this I have not found to be a practical objection. If one has to go deeper in the hand or foot than the layers of tendons and their sheathes it is always possible to dissect carefully through between the tendons in the direction of their long axis, and after having worked one's way beneath them continue the dissection, or rather

the incision, again at right angles to the foreign body: in this way there is no occasion to do unnecessary damage to the tendons or open their sheathes extensively, if at all. By bearing in memory the situation of the more important vessels, the above equally applies to them.

2. *Use no force in the way of probing, inserting fingers, etc., into the wound until the depth at which the body is situated from the skin has been reached.* It is often then possible to hit off the body with the cutting edge of the scalpel without probing being necessary. On several occasions one has found the body displaced as much as half an inch from its original position on again skiagraphing, after operations lasting from a quarter to one hour.

3. *When the foreign body can be felt and gripped by forceps, supposing it to be a long substance like a piece of needle, work it in one direction of its long axis until an end be made to present in the line of incision before pulling on it.* If this rule be not observed, there is great liability of the foreign body breaking and giving unnecessary trouble.

Should the body not be found within, roughly, ten minutes from the commencement of the operation, it is quite unjustifiable to proceed without again skiagraphing, and so taking every advantage of this valuable surgical auxiliary. In the near future the correct thing will be to operate on all cases for foreign body extraction under the X Rays; by this I mean screening whilst the operation proceeds. Thus, should the object of one's search move during manipulation it will be possible to insert a probe, screen and observe the position of the probe in relation to the foreign body. By this method we have on one or two occasions extracted pieces of needles which have been operated upon as long as an hour and an hour and a half by others unsuccessfully. The objections to this mode of procedure are from a point of view of asepsis. This difficulty can be quite overcome by operating on a vulcanite table covered, if need be, by sterilized and antiseptic towels.

In a large number of cases, if the above rules be observed, a general anæsthetic is quite unnecessary, ethyl chloride spray or an injection of eucaine being all that is required. What one has found a good method is to inject ten or fifteen minims of five per cent. solution of eucaine, leave for three minutes, spray the skin with ethyl chloride and immediately proceed with the operation; the reason for employing these two anæsthetics being that in one's experience eucaine fails to give satisfactory cutaneous anæsthesia, whilst the spray cannot be used after the skin incision has been made.

Cocaine, generally speaking, is not suitable.

A. H. B. KIRKMAN.

Solution of Case for Diagnosis, page 14.

A post-mortem examination revealed extensive tubercular meningitis with general miliary tuberculosis. No pus was found in the brain substance.

Reviews.

A Manual of Surgery. By Rose and Carless. (Bailliére. 21s. net. 2nd edition).

The first edition of this book was reviewed by the *Gazette* just a year ago, and the issue of a second edition so soon testifies to the excellence of the work and to its practical utility.

Most of the points then emphasized by the reviewer have received attention by the Authors, Mr. Symonds receiving the credit due to him for having so enthusiastically revived Socius' operation, although the boiling of instruments still seems to be out of favour with the King's College Surgeons.

Many of our readers are quite familiar with this work, and any detailed account of it is quite superfluous. The whole book has been carefully re-edited and much new material re-added.

From the Gazette's Special Pathologist.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

NOTICES.

H. B., BUILTH WELLS.—Tubercle bacilli are present in the sputum in considerable numbers, and show a marked tendency to appear in "clumps."

G. M. G.—No tubercle bacilli could be found in the fluid.

C. P., BARTON-UNDER-NEEDWOOD.—The fluid does not differ from ordinary pleuritic effusions. It has a faintly alkaline reaction, a sp. gr. of 1021, and contains a considerable amount of albumen. *Microscopical examination.*—The centrifugalized deposit is scanty, consisting chiefly of red blood discs, with numerous leucocytes and some pleural cells. No tubercle bacilli could be found. No urates are present in the fluid.

PATHOLOGIST.

Marriage.

McGREGOR—CRAMPTON.—On December 27th, at All Saints Church, Landport, by the Rev. W. Hawksley, M.A., Vicar, Surgeon George McGregor, R.N., of H.M.S. *Caledonia*, to Ada, elder daughter of J. T. Crampton, Esq., of Albion House, Portsmouth.

ED.—H. L. E.

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Calendar of Coming Events.

January, 1900.

Sat. 20.—Messrs. Davies-Colley and Symond's take-in; Drs., J. D. Bridger and E. Shelton-Jones; Cl., D. G. Greenfield.
1 p.m., Clinical lecture by Dr. Bryant.
G.H.R.F.C., I.—Rosslyn Park, home.
II.—Hammersmith, away.
III.—Beckenham, away.
G.H.P.P.S.—Paper by C. T. Hilton, "The pupil as a factor in diagnosis."

Wed. 24.—1.15 p.m., Clinical lecture by Mr. Golding-Bird.
G.H.R.F.C., II.—St. Bart.'s Hospital, home.

Thur. 25.—Messrs. Lucas and Lane's take-in; Drs., F. S. Gibson and K. V. Trubshaw; Cl., T. G. Cross.
G.H.C.U.—Address by Rev. T. B. Meyer.

Sat. 27.—1 p.m., Clinical lecture by Dr. Bryant.
G.H.R.F.C., I.—Harlequins, away.
II.—Streatham, home.
III.—Dulwich College II., away.
IV.—K. C. Engineers II., away.
G.H.A.F.C., I.—Beckenham, home.

Wed. 31.—1.15 p.m., Clinical lecture by Mr. Golding-Bird.
G.H.A.F.C., I.—Royal Vet. Col., away.

February.

Thur. 1.—Messrs. Golding-Bird and Dunn's take-in; Drs., P. T. Manson and M. D. Wood; Cl., O. Marriott.
G.H.C.U.—Address by H. T. Hodgkin, Esq. (St. Thomas's).

Sat. 3.—1 p.m., Clinical lecture by Dr. Bryant.
G.H.R.F.C., I.—Catford Bridge, away.
II.—Marlborough Nomads, home.
III.—Sidcup "A," away.
IV.—Catford Bridge IV., away.
G.H.A.F.C., I.—Ewell, home.
II.—Ewell II., away.
G.H.P.P.S.—Pathological Meeting.

Guy's Hospital Gazette,

JANUARY 20, 1900.

Adherent Pericardium.

CLINICAL LECTURE BY DR. PERRY.

December 2nd, 1899.

GENTLEMEN,—I have chosen for my subject this morning the consideration of Adherent Pericardium. I have chosen it for two reasons. One is that the condition has great clinical interest, and the other is that it is somewhat inadequately treated in text-books. In fact, one might venture the assertion that the statements of certain writers are not only inadequate but actually erroneous. And as it is the custom to begin a clinical lecture with an abstract of a case, I venture to mention to you two cases in which you have the advantage of seeing the heart, with adherent pericardium, in a preparation-glass.

The first case is that of a man, who was twenty-one years of age, and was admitted under Dr. Owen Rees with symptoms of heart disease, for which he had been on many occasions under treatment. No bruit was at any time discovered. His most prominent symptoms were cyanosis, dyspnœa, and coldness of the extremities. These conditions were aggravated in cold weather and often relieved by epistaxis. He was thought to be suffering from some congenital affection of the heart. He became water-logged, and the veins all over the body were distended. At the autopsy the right side of the chest contained two pints of fluid, the left pleural cavity was obliterated, and both lungs were adherent to the pericardium. The heart was enlarged and altered in shape, each auricle being at least double the normal size.

The next case was the case of a man who was twenty-six years of age, and was admitted in 1830 for urgent dyspnœa. Five weeks later he died. At the autopsy the lungs were found to be in a condition of brown induration. I may here add that there are no auscultatory signs mentioned in the clinical account. Here is the specimen, and it shows, as the other does, the heart covered by an adherent pericardium. It shows, not so plainly as the other specimen, that the valves are healthy, and under the microscope there is no evidence of any fibroid change in the muscle.

Now I am sure you will bear with me for a few minutes if I mention to you the way in

which adherent pericardium comes about. Nowadays it seems almost a truism to repeat that it is the result of chronic inflammation, but in earlier days, at the beginning of the century, it was thought that adherent pericardium was a congenital condition, and it was not considered that inflammation had anything to do with it.

Adherent pericardium, then, is the result of a complete pericarditis, and the pericarditis begins, as many of you know, with slight roughening of the serous surface of the sac. We may have either pericarditis of a dry or plastic variety, or pericarditis with effusion. The effusion may become absorbed, and thereafter we have a layer of fibrous tissue of varying thickness. In some cases the thickness is little, the adhesions are filamentous in character, and no effect is produced on the cardiac muscle. In others the adhesions are fibroid, and in some cases undergo calcareous change. In one of these specimens that change has happened in an adhesion over the front of the right auricle.

The teaching which we adopt here seems, as far as I can judge, to come very much from Dr. Wilks, and in an excellent paper which he wrote upon this subject in 1871 he answers the question as to the importance of pericardial adhesions in these words: "The answer probably is that the loose cellular adhesions have no appreciable influence on the action of the heart, but that the thickened pericardium of a cartilagenous consistency investing the heart closely, arising from inflammation at an early period of life, does lead to obstruction of the circulation, and then to dropsy after the ordinary manner of heart disease."

In preparing for a lecture on this subject I have investigated our records of Inspections for ten years in cases where post-mortem examinations have been made, and the results of these records are, I think, interesting. It comes to this: that an adherent pericardium is found in one in thirty of all. When the pericardium is adherent, about once in every fifteen cases it causes death by cardiac failure without valvular lesions. Altogether in the period under review we have something like one hundred and fifty-three cases in which pericardial adhesions were found. And the age at which they occur may be variable within very wide limits. Adhesions have been found in a child of ten weeks old, where possibly they were due to a congenital affection of the pericardium. But they have also been found in patients up to the age of nearly eighty years. One patient had an adherent pericardium at seventy-nine, and died with meningeal hæmorrhage; another such case died at seventy-seven with cerebral softening; another at seventy-six with cerebral hæmorrhage; another at seventy-two with senile gangrene; and another at seventy with chronic bronchitis.

It appears, therefore, quite certain that, as has been taught, an adherent pericardium may produce no symptom, and may not interfere materially with the duration of life, and it is true that it is not only loose cellular adhesions but pretty tough adhesions which may exist without damage. A considerable number of these cases at any rate have shown adhesions of this character though separable without laceration of the heart-muscle.

More interesting, perhaps, is it to enquire, What are the causes of adherent pericardium? and, as might perhaps be expected, acute rheumatism and chorea come easily first. Out of one hundred and fifty-three cases there were sixty-five of rheumatic fever and chorea, twenty-three of tubercle, and nine of nephritis. Those are the chief causes. Then come aneurysms—three cases: mediastinal growth two, syphilis three, scarlet fever, two cases; pleurisy and empyema, three cases; congenital disease (?) one case. The last is the case where adhesions were found in a child ten weeks old. In forty-two cases no reason can be assigned. I suppose many of these cases may have been due to acute rheumatism, though in patients dying late in life of such diseases as chronic bronchitis and cerebral softening, the clinical history may fail to elucidate the question of rheumatic fever in youth. I do not think that any text-book I have read has brought out clearly what are the causes of adherent pericardium, and the number of cases in which tubercle and nephritis are apparent causes, has somewhat surprised me. Rheumatic fever and chorea have the great preponderance one would naturally have attributed to them.

We have now to consider the causes of adherent pericardium, in the *fatal* cases—ten in number—investigated, where, to repeat what I said, death was due to chronic cardiac failure without valvular lesion of the heart. Rheumatic fever and chorea answer for seven, scarlet fever for one, and no cause is given with regard to the two other cases. I suppose, therefore, in fatal cases enquiry will commonly elicit a history of rheumatic fever, even though in the young, articular symptoms are less well marked than in older subjects.

A point which must be strongly brought out is the age at which patients die from adherent

pericardium. Many text-books fail to lay due stress upon this fact, and yet the result of our recent investigations, and of Dr. Wilks' investigations years ago, seems to show that practically every patient who dies from an adherent pericardium without valvular lesion dies before he is thirty years of age. And it is true of the great bulk of the cases to say that they die before they are twenty. Of the ten cases that I have tabulated, four died between one year and ten years, five between eleven and twenty, and one at thirty. So that it is probably true that the greater number are fatal by twenty. And the deduction is that you will be very chary of diagnosing adherent pericardium without valvular lesion as a cause of cardiac failure in a patient who is over thirty years of age; you will be more chary in diagnosing it between twenty and thirty than in the first twenty years of life. A perusal of some text-books might give the impression that a patient may die even late in life from adherent pericardium without valvular disease.

The clinical signs of adherent pericardium have troubled observers much, and even now there is nothing that can be said to be pathognomonic. The diagnosis has to be made upon probability rather than upon absolute physical signs. But the physical signs may be tabulated under the usual heads of Inspection, Palpation, Percussion, and Auscultation; and I am never tired of reminding men to do their work for examination purposes, and even for their own benefit, in a systematic way, regarding each case under these heads.

On inspection the precordial region is likely to be bulging, I say, *likely to be*, because, as I shall subsequently mention, in all these fatal cases the heart is considerably enlarged, and, moreover, an enlargement of the heart occurring in early life generally leads to a one-sided enlargement of the chest, showing itself as a prominence in the precordial region. The cardiac impulse is likely to be diffused from the dilatation of the heart which takes place, and the point that is dwelt upon in this relation is the systolic retraction of the intercostal spaces at the apex and for two or three spaces above. It has been questioned, first, whether this sign is of any value, seeing that in many cases where the pericardium is not adherent, slight retraction may be seen at the systole; and, secondly, whether it can occur unless not only the pericardial layers are adherent to the heart, but the pleura over the pericardium is adherent, and so adherent as to drive back the edge of the lung at that part.

A point which is worthy of your investigation is emphasised in Dr. Osler's valuable text-book. It is what he calls the "diaphragm phenomena." It depends upon the adhesion of the heart to the diaphragm, and when systole takes place there is a tugging of the diaphragm upwards, showing itself as a systolic retraction in front between the seventh and eighth ribs in the parasternal line, and behind between the eleventh and twelfth ribs. Now I should like you seriously to investigate this symptom in the wards, because, as I say, it is one to which little attention has been directed in this place. It may be of very considerable importance. If so, it is well that you should learn it. There is also a symptom described as diastolic collapse of the cervical veins, which few regard as of much importance.

Turning now to palpation, it is said that there is a diastolic shock felt on placing the hand over the præcordia. A sign that is mentioned in older text-books is the elevation of the apex to the left. The heart was thought to be pulled up by pericardial adhesions continuous with indurated fibroid tissue in the mediastinum, and when thus pulled up, the organ itself being enlarged, the apex beat was displaced upwards and outwards. That is a symptom which I have not myself been able to verify. It is also said that some information may be gained by making a patient move in one direction and another, and that when the pericardium is adherent, the position of the apex beat is not altered by the position of the patient.

It is an interesting point that in some of the fatal cases of which we have records there has been a thrill. It occurred in two out of the ten fatal cases which I have mentioned, and in one of them it was systolic in time, and in the other it was diastolic.

On percussion the cardiac dulness is usually increased, as might be expected, from the enlargement of the heart. It is said, too, that the dulness is not diminished on inspiration. If that is so, it must be due to adhesion of the pleura over the pericardium.

We now come to the more important question of auscultation. In this matter the text-books do not afford you very definite information. As far as our own examination of cases goes, it appears that out of the ten cases there was no bruit at all in two of them. In four cases, as might perhaps be expected, there was a soft systolic bruit. What, however, is, I think, interesting, is that in an equal number of cases there was a diastolic bruit. It is worth while remembering that an adherent

pericardium alone will lead to a diastolic bruit, audible generally at the apex, and in the situation in which a diastolic bruit may be heard in mitral stenosis, the explanation of the bruit probably being that there is what is called a relative stenosis, the mitral orifice of the normal size being relatively too small for the hypertrophied and dilated heart.

That leads me to consider the question of the size of the heart in these fatal cases, and according to our observations the heart is always enlarged. I have a list of them here. The first was a female seven years old; her heart weighed seven ounces. The next was a male seven years of age, with a heart of seven ounces. The next a male of eight years of age, with a heart of ten ounces. The next a male of nine years old, with a heart of seven and a half ounces. The next a female of ten years, with a heart of thirteen ounces. The next a male of eleven years, with cardiac hypertrophy and dilatation--no weight given. The next a male twelve years of age, with a heart weighing thirteen and a half ounces. The next a male of thirteen years, with a heart of twenty-two ounces. The next a male fifteen years old, with a heart weighing twenty-one ounces. In the last case there was cardiac hypertrophy and dilatation, but no weight is recorded. So that in all these cases we may note that the heart is enlarged.

It appears, however, from Dr. Wilks' cases, that occasionally the heart is not enlarged in fatal cases. And teaching upon this subject has somewhat varied. By some it was thought that pericardial adhesions caused obstruction to the heart in its action, and consequently the heart hypertrophied to perform the extra work required of it, the hypertrophy being generally rather more on the right side than on the left. On the other hand, there were observers who said that pericardial adhesions tended to diminish the size of the heart, inasmuch as they constricted it, and the heart was, so to speak, strangled by them, the muscle consequently undergoing atrophy or fatty degeneration.

Both these statements have some basis of fact, but what we seem to have learned is that in fatal cases it is hypertrophy rather than atrophy that is to be expected.

A further point is the effect of the fibroid tissue upon the muscle beneath. Dr. Wilks has regarded a fibroid pericardium as analagous to a fibroid lung, and he has seen fibroid septa in the myocardium, just as fibroid septa pass from the pleura into the pulmonary tissue. But so far as our microscopical examination has gone, we have not found that the muscle presents any evidence of fibroid change. It does present evidence of fatty degeneration, such as may be found in most cases of fatal cardiac lesions.

Having thus traced the physical signs, which may be present in adherent pericardium, it remains to say a word or so on the course of the disease. It is very well indicated in the first case which I read to you. The patient has the common signs of cardiac hypertrophy and dilatation,—a weak, intermittent, irregular pulse, œdema, ascites, and cyanosis, such cyanosis being at times so considerable as to lead, as in this case which I read to you, to the suspicion of a congenital heart disease. The usual changes take place in the lungs—splenisation, brown induration, and the rest. So that clinically the picture is that of a patient dying from chronic cardiac failure, and if we find a young subject under the age of twenty presenting these symptoms, with or without the bruits above described, we shall do well to consider an adherent pericardium as a possible explanation of his condition.

One word as to the association of adherent pericardium with mediastinitis and pleuropericarditis. Of the ten cases of which I have spoken, it appears that only in three was there any adhesion of the pleura; in the case of one girl there were adhesions on the left side, in the case of a boy there were adhesions on both sides, and in the case of a male, of fifteen years old, there were adhesions on both sides. But in all the other cases the pleuræ were absolutely free and there was no mediastinitis. And therefore it is well for you to bear in mind that the division of adherent pericardium into the two groups recognised by Dr. Osler is defective as a clinical guide, seeing that an adherent pericardium of the "simple" type may apparently lead to death by progressive cardiac failure.

Papers by Guy's Men.

An Address on Acidity. By James F. Goodhart, M.D. Aberd., LL.D.—*Lancet*, 6th January.

The Histology and Prevention of Blackwater Fever. By W. H. Crosse, M.R.C.S. Eng., L.F.P.S. Glasg.—*Ibid.*

A Case of Hæmorrhagic Ascites. By Theodore Fisher, M.D., M.R.C.P. Lond.—*Ibid.*

A Successful Case of Removal of a Packing-Needle from the Descending Colon (under the care of Mr. N. Davies-Colley).—*Lancet*, 13th January.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

CASES UNDER DR. TAYLOR.

MARY 41. Chronic Bright.
43. Acute Bright.
45. Chorea.
46. Locomotor. Charcot's joints.
48. Gastric ulcer.
Cot 56. Broncho-pneumonia.
PHILIP 22. Mitral stenosis. Ascites. Compressed left lung.
24. Dilated stomach. ? Growth.
25. Left pleuritic effusion. Aspiration.
30. Traumatic paraplegia.
31. Appendicitis. Operation.
32. Enteric. Twelfth day.
35. Hæmoptysis. Diarrhœa. Enlarged liver.
37. Lymphadenoma,
40. Infective endocarditis.

CASES UNDER DR. HALE WHITE.

MARY 13. Chorea.
15. Acute rheumatism.
20. Abdominal tumour (transverse colon).
22. Bronchiectasis. Thickened pleura.
23. Phthisis.
24. ? Cerebro-spinal meningitis.
PHILIP 1. Enteric.
2. Aortic obstruction and regurgitation. Mitral obstruction.
3. Subacute peritonitis and ascites.
9. Acute rheumatism. Aortic obstruction and regurgitation. Mitral regurgitation.
10. Chronic bronchitis. Mitral regurgitation. Cirrhosis of liver.
12. Diabetes.
13. Hemiplegia and aphasia. Cerebral hæmorrhage.
14. Chorea. Mitral disease.
18. Double pneumonia and pericarditis.

CASES UNDER DR. PITT.

MARY 26. Acute pneumonia. Phthisis.
27. Mitral stenosis and regurgitation. Tricuspid regurgitation.
29. Pyrosis with vomiting.
30. Chronic bronchitis.
31. Hæmatemesis. Gastric ulcer.
33. Typhoid.
34. Acute rheumatism.
35. Ascites.
36. Right pleuritic effusion.
STEPHEN 23. Stricture of œsophagus. Gastrostomy.
24. Chronic bronchitis.
25. Influenza. Pneumonia. Right base.
26. Pneumonia. Left base.
28. Right pleuritic effusion.
29. Mitral and aortic stenosis and regurgitation.
32. Chorea.
34. Chorea.
35. Alcoholism and phthisis.
37. Mitral and tricuspid stenosis and regurgitation.
39. Locomotor ataxy.
40. Hæmatemesis. ? Cirrhosis.
Cot —. Broncho-pneumonia. Mitral incompetence.

CASES UNDER DR. PERRY.

MARY 1. Bronchitis. Healed phthisis.
2. Chronic peritonitis.
5. Chlorosis. Mitral regurgitation.
7. Pernicious anæmia.
9. Mitral and tricuspid disease.
Cot 52. Intussusception. Operation.
STEPHEN 1. Secondary syphilis.
2. Dry pleurisy.
3. Enlarged heart.
6. Dilated heart. Pleurisy with effusion. Tricuspid regurgitation. Granular kidney.
8. Spinal meningitis. ? Gummatous.
9. Growth of lung.
10. Phthisis. Cavitation.
12. Abdominal colic.
13. Acute rheumatism.
14. Gout.
15. Acute rheumatism.
16. Laryngeal obstruction. ? Foreign body. Tracheotomy.
17. Eczema.
18. Tubercular pyo-pneumothorax.
19. Mitral stenosis and regurgitation. Aortic regurgitation.
20. Acute rheumatism. Mitral and aortic stenosis and regurgitation.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

ASTLEY COOPER 3. Depressed fracture of ribs.
11. Dorsal dislocation of right femur.
NAAMAN 3. ? Iliac abscess.
5. Inguinal hernia. Varicocele.
8. ? Congenital abscence of head of right femur.
14. Traumatic stricture of urethra.
15. Keloid (caseating).
17. ? Vesical calculus.

DORCAS 3. Torticollis. Operation.
4. Mammary abscess.
6. Strangulated femoral hernia. Operation.
9. Thrombosed veins on left leg.
14. Hæmorrhoids.
16. Tubercular knee. Excision.
18. Epithelioma of cheek. Excision.

CASES UNDER MR. DAVIES-COLLEY.

CORNELIUS 8. Hæmatoma of thigh. Suppuration.
9. Compound fracture of right leg. Amputation. Compound fracture of left leg. Comminuted fracture of right humerus. Fracture of right radius and ulna.
12. Fractured tibia and fibula.
17. Fractured patella. Hæmarthrosis.

JOB 7. Ankylosed hip (tubercle). Gant's operation.
8. Ankylosed hip (pyæmic). Adam's operation.
9. Fracture of humerus. Necrosis. Incision.
10. Enlarged prostate. Suprapubic puncture.
20. Fibro-adeno-myxoma. Excision.
22. Double congenital inguinal hernia. Radical cure. Left side.
25. Alveolar abscess. Incised within mouth.

LYDIA 2. Strangulated femoral hernia. Operation.
3. Morbus coxæ (early). Extension applied.
5. Morbus coxæ.
10. Osteitis.
13. Tubercular elbow. Excision.
14. ? Arthritis.
15. Osteitis of great toe.
16. Compound fracture of tibia and fibula.

CASES UNDER MR. LUCAS.

ASTLEY COOPER 4. Cut throat.
8. Abdominal contusions. Subconjunctival ecchymoses.
21. Separated epiphysis of lower end of femur. Reduced.

LAZARUS 1. Tubercular glands. Removed.
4. Large inguinal hernia. Operation, January 17th.
6. Recurrent epithelioma of cheek. Removed January 13th.
7. Varicocele. Operation.
15. Ununited fracture of tibia and fibula. Previously wired. Screwed.
16. Varicocele. Operation, January 17th.
20. Inguinal hernia. Radical cure.

MARTHA 1. Multiple tubercular lesions.
2. Talipes equino-varus.
4. Congenital dislocation of hip.
8. Irreducible umbilical hernia. Operation.
17. Early hip disease.

CASES UNDER MR. GOLDING-BIRD.

ASTLEY COOPER 7. Fractured tibia and fibula.
14. Compound tibia and fibula.
20. Supra-condyloid fracture of femur.
25. Hæmatorachia.

CORNELIUS 3. Fractured right femur. Separation of lower epiphysis of left femur.
7. Concussion.
20. Acute suppurative arthritis.

LUKE 6. Abdominal tumour. Exploration.
9. Hæmaturia. ? Bladder.
10. Extravasation. Cock's operation.
11. Extravasation.
12. Stricture. Supra-pubic puncture.
14. Epithelioma recti.
15. Hæmorrhoids.
17. ? Inguinal hernia.
18. Cirrhosis of liver.
19. ? Empyema. ? Mediastinal growth.

CHARITY 6. Sarcoma of scapula. Removal.
7. Fractured tibia and fibula.
10. Caries of spine.
11. Hammer toe.
13. Periostitis of humerus.
16. Carcinoma mammæ.
17. Perinephritic abscess.
19. ? Carcinoma of cæcum.
22. Ankylosis of elbow. ? Gonorrhœal.

CASES UNDER MR. JACOBSON.

NAAMAN 19. Tubercular ankle. Operation.
20. Undescended testis. Removal.
21. Double variocele.

DORCAS 20. Goitre.
22. Glands in neck. Malignant.

PATIENCE 2. ? Gonorrhœal synovitis. Inflammation of rectum.
3. Sloughing of tissues in left groin. ? Impetigo of lip.

SAMARITAN 8. Diabetic necrosis of toe.

CASES UNDER MR. SYMONDS.

JOB 13. Stricture of œsophagus.
14. Horse-shoe kidney.
17. Epithelioma linguæ.

LYDIA 19. Tubercular abscess of breast. Amputation.
20. Renal calculus.
21. ? Ovarian tumour.
22. Odontoid cyst.

PATIENCE 4. Periostitis of tibia. Incised.

SAMARITAN 9. Abscess. Caries of ribs.

CASES UNDER MR. LANE.

LAZARUS 9. Periosteal sarcoma of upper end of tibia. Amputation above knee.
12. Adenoma of thyroid. Removed.
13. Carcinoma recti. Colotomy.

PATIENCE Cot 6. Tubercular dactylitis. Tubercular carpus.
SAMARITAN 11. Sarcoma of roof of mouth. Removal of superior maxilla.

CASES UNDER MR. DUNN.

LUKE 1. Inguinal hernia.
2. Tuberculous glands in neck.
3. Tuberculous knee.
4. Carcinoma pylori.
CHARITY 2. Varicose veins.
3. Carcinoma mammæ.
Cot. ? Arthritis of knee following exanthem.
SAMARITAN 7. Dogbite of arm.

With the Army Medical Corps in South Africa.

(BY OUR SPECIAL CORRESPONDENT.)

No. 1 General Hospital,
Wynberg, Cape Town,
Tuesday, December 19th, 1899.

I WAS down at the station the other day assisting in the detraining of the wounded officers and men from the Magersfontein fight. The battle was on Monday; the hospital train left on Tuesday evening at ten: on Thursday at one it was at Wynberg; and by three all the wounded were comfortably ensconced in their beds here. You good people at home, and the bad ones too, think no doubt of the horrors of a trainful of wounded fresh from the battle-field; and the laity of course draw lurid pictures to themselves of the maimed figures and the pools of blood. But as a fact there is nothing of the sort. At the worst there are a few coats splashed with dark red; a few arms in slings; a few heads and faces bandaged up; and a few cripples who can just hobble across the platform to their seats in the ambulance wagons. But as a general rule the fractures have been thoroughly well put up in splints: the wounds have at least not yet had time to have developed much uncomfortable suppuration; and the men have been revelling in the comfort of their bunks on board the train, and in the milk and soda, tobacco, and other good things which good ladies would thrust upon them at every conceivable opportunity throughout the journey. Our transport officer, Major Elderton, R.A.M.C., one of the best, on Thursday gave two ladies leave to come on the platform and administer their harmless drinks; whereupon all the good ladies of Wynberg and the vicinity seemed to swarm round us and had to be repulsed—with great loss on both sides.

The train is certainly very well designed. As is usual in the service, one of the majors drew out the design most elaborately after the Tirah campaign; and the colonel at Cape Town alone gets the credit. It consists of a series of carriages; two of which are fitted up as dispensaries and kitchen; while a third, more or less after the model of an ordinary corridor-carriage, is designed with separate sitting and sleeping compartments for the captain of the A.S.C., the major of the R.A.M.C., and the civilian surgeon, who live on the train. The remaining carriages are divided longitudinally into about three equal parts, the central part being the corridor, and the parts on either side the bunks in which the patients lie with their heads towards the engine or facing the engine, in two tiers, one above the other, one about a foot off the ground and the other about the level of one's chest. Thus every patient can be properly attended to on the voyage, and can easily be transferred on to a stretcher at the end of it. The stretchers, which run on wheels when on the ground, and make quite comfortable couches in themselves, are transferred bodily to the railway platform just outside the hinder end of an ambulance wagon, the floor of which is at the same level as the platform. They are then run into the wagon, two to each wagon, side by side, with two sitting up cases on seats at the end, two more such cases on the box, and an orderly behind as conductor. The black driver is bidden in suitable language to move off; he starts his pair of formidable mules with a flick of his long whip; and at a slow walk the caravan makes its way a mile uphill to the hospital. Here squads of orderlies are in readiness to carry the patients up to the wards where "convalescent diet" is in waiting for them. The head ward-orderly comes in from the store and brings the hospital kit—comfortable, loose blue flannellette coat and trousers of enormous and uniform length, which generally have to be turned up five inches, showing the white lining at the bottom; and a flannel shirt apiece; the old blood-stained and tattered kharkis with such equipment as survive are packed off to the store, and in an hour the ward is ready for the services of the medical officer. Then comes a field day for the medical officer, the nursing sister—if available—and the orderlies. Very few of the dressings have been changed on the way down, and several are dressed only with the field dressing—a bit of gauze or lint soaked in carbolic oil with jaconnette and a bandage—hurriedly applied under fire by a comrade; and of course several are already very foul. One ought therefore to dress every case the first night, and on the last occasion it gave me and my staff five hours' hard work from 5 p.m. to 10 straight on end, before I could leave the place with a fairly clear conscience. In the way of dressing wounds on board the train things are better now that the train staff has settled down to its duties, and that the worst cases are left at De Aar or Orange River. In last Thursday's lot, twenty-eight had thus been left behind *en route*. But in the first batch, that from Belmont, when we had the most serious cases sent straight down here, and when the train was greatly overcrowded with men lying and sitting about on the floor of the corridor, the medical staff were unable to do anything more than administer food and stimulants and attend to urgent requirements. This may account for our mortality in fractured thighs, practically all our cases of fracture in

the upper half having proved fatal. Despite thorough drainage, the end has proved fatal in two or three weeks, osteo-myelitis, profuse suppuration of the adjacent tissues and bed sores being the inevitable result. However, Mr. Makins, who was down here again this morning, and hopes to be in a field-hospital at the next battle, tells me that they have now half-a-dozen of the worst fractured thighs at De Aar on Hodgen's splints. Despite the dust and heat, which there runs up to 107, in a double-fly tent for three hours every day. Mr. Makins' book, which we hope he will write, should be intensely interesting. He flies about at his own will from the front to the base, sees the best of everything, takes some useful notes, and is welcomed by everyone, not least by ourselves, who are only too glad of a sound and kindly opinion on our more difficult cases. No doubt Mr. Purves is doing the same, but as he is in Natal we don't see anything of him. I only wish we had a Guy's surgeon out here, Mr. Jacobson, Mr. Dunn, Mr. Fripp, or any other exponent of sound surgery, to counterbalance the preponderating influence of men from St. Thomas's, St. George's, St. Bartholomew's, and even gallant little Middlesex.

Bullet seeking is the order of the day. Yesterday I bagged a Mauser, a ·303 sporting, and a shrapnel shot from three different patients. About the fourth we do not talk much—a thigh in which the bullet had entered in front and was declared by the patient to be lying subcutaneously close to the wound, where a definite lump could be felt. The lump must have been a blood-clot, for after five minutes' vain exploration it was decided to use the skiagraph before proceeding further. This afternoon it was the turn of another man, who, in lying down behind a comrade during Monday's battle, was hit by a bullet which had passed through the comrade's shoulder. The wound was in the cheek and the only symptoms were a loosening of the upper teeth, a vague dimness of vision in the right eye, swelling and tenderness of the cheek, and a slight but persistent headache over the eyes. With the screen we were able to see the bullet, indistinctly but definitely, extending from below the middle of the right orbit to the last molar tooth. Under operation a neat opening was found in the superior maxillary. This was enlarged and the bullet was found at the very back of the antrum and extracted without much difficulty.

Amongst my patients are several with wonderful bullet tracks. One, for instance, has a slight wound of entrance near the larynx, now healed, and an exit wound near the left scapular angle, leaving the patient practically uninjured. Another with a wound, now healed, just below and behind the knee, has complete drop foot, presumably from severance of the external popliteal nerve. A third was shot in the right side, near the top of the liver. The wound has healed and the patient is almost well; but there is a roaring pleurisy on the other side. A fourth with a single wound in the front of the throat, has a husky voice, some inequality of the pupils, and now slight hæmoptysis. But I rather believe this is only a grazed wound, and that the hæmoptysis is due to a fractured rib which arose from a subsequent fall.

Altogether we are busy and the work is good. We hope to celebrate Christmas next Monday in suitable fashion, and shall think of you doing the same.

Tuesday, December 26th, 1899.

No. 3 has started at Rondebosch, where Mr. Rhodes lives, half-way between here and Cape Town, on the camp-ground, where the air is very nearly as fine and the view as splendid as here. No. 3 received its first batch of wounded last Saturday—a ship-load from the Spartan, who had brought the men straight down after the Colenso fight. The officers came on to us, as we differ from the other general hospitals—firstly, in being installed in huts instead of tents; secondly, in taking the wounded Boer prisoners; and thirdly, in treating all the wounded officers. Besides the building, which was originally the officers' mess for the camp and was converted into a very comfortable hospital for 36 wounded officers, we have now turned the "permanent hospital" of the camp into an officers' hospital, and have thereby an extra 75 officer-patients. These, with 50 additional wounded N.C.O.'s and men, make our total up to 620, instead of 500 provided for, and the hospital staff is taxed to the uttermost. The strain especially falls on the wretched orderlies of the R.A.M.C., who are on night duty every other night, besides being on day duty from 5 a.m. to 5 p.m. every day. Night duty with them means two hours on and two hours off through the night, the duty-hours being spent, as a rule, in visiting each of three huts in turn; while the off-hours are spent in trying to sleep on tables and benches or on the ground round the guard-tent. Naturally this kind of life leads to festivity, as an antidote, whenever the orderlies get a free evening, with confinement to barracks or cells for a few days, and a good deal of discontent as a result. The whole system is bad, and is due not to the exigencies of war, but to the exigencies of a slowly-developed, hide-bound, almost mathematical system, clogged with petty trivialities and hampered at every turn by an excess of officials, official returns, and all the paraphernalia of red-tape. The R.A.M.C. people feel this as much as ourselves; indeed, it is the root of their discontent. It must all be changed, but now is not the time to change it. We must make the best of existing conditions during the war, and hope afterwards for a thorough, an impartial, and yet a kindly critical investigation into the whole subject. This is the opinion, I believe, not of one, but of all the civilian surgeons working in No. 1 General Hospital, and those of No. 2 and No. 3 think doubtless the same.

In making up my notes of cases, I have had a good opportunity of realizing the story of the wounded on the field of battle. In the battle of Magersfontein, on the 11th December, the regiments that suffered the most were the 2nd Black Watch, the 2nd Seaforths, the 1st Coldstreams, the 1st Gordons, the 1st Argyll and Suther-

land Highlanders, and the 1st Highland Light Infantry. The battle began before daybreak, and as soon as light appeared several companies found themselves close up to the Boer forces, who were pouring a deadly fire into them. Some companies were ordered to advance, and advancing, got right up to the first line of entrenchments, but being almost decimated were obliged to retire. Others retired to advance again, while a large proportion lay down flat on the ground and let the fire mainly pass over their heads. Indeed, the companies who lay down, even within 200 yards of the enemy, were in far greater safety than those that retired, or others that took what cover they could get from the bushes on the veldt, which were simply riddled with the enemy's fire. In lying down, however, many suffered somewhat severely from being trampled on by the regiments in front retiring. This danger past, the men had to take their chance, and if they stirred but a finger they were liable to draw down on themselves a hail of bullets. One man lay with his arm under him for five hours straight on end, and towards the end was made the mark of a particular Boer rifle. At last, as his arm was severely cramped, he took advantage of a bullet splashing up the ground close by to turn over on to his back and feign death. The succession of bullets ceased, but he had to lie unmoved, with his face exposed to a brilliant sun, for the rest of the afternoon, and he escaped with only a bullet in the thigh, from which it was easily extracted. Another fellow, a drummer, who had seized the rifle of a wounded soldier and the ammunition pouch of a dead one, was shot in the knee, but not daring to move again, even in order to look at it, stayed till evening with his wound untouched, and then found himself lying in a pool of blood. This is only one of many similar instances.

A serjeant of 10 years' service, who has been recommended for gallantry, was shot in the side. The shot only felt like something hot striking him, and he noticed afterwards that it bled so profusely that his kilt was soaked, and had to be thrown away. He went on superintending his men, but when he found it advisable for them to retire, he had no sooner raised himself from the ground than he found his thigh fractured. He had to lie where he was, without any treatment, until nightfall. During the night many Boers came out on to the field and gave water to several of our men as well as their own wounded. Knowing a little German, we hailed one, "Hoch, Camarade," and "Camarade" proved to be General Cronje, who said he could not take the wounded English into his camp, as he had not the ambulance or surgical arrangements necessary for them. And so he lay all that night; and another of my patients, who also lay out all night, said they could distinctly hear the Boers singing and praying in their trenches. The next day at noon the Cape Volunteer Ambulance came along, and after a miserable journey to Modder River Hospital, the serjeant's leg was tied up with splints and dressings, thirty-six hours after he had received the wounds. But most men were treated more rapidly. A comrade generally applied the field-dressing, and after waiting two or three hours for the fire to slacken, they crawled back from cover to cover as best they could, or were helped back on stretchers to the field hospital. Many lay out behind the artillery as they fired, and stayed there the whole night. Others were promptly treated and removed to Modder River Hospital, and thence the next day to Orange River or De Aar. The medical officers appear to have worked splendidly; but their gallantry was not an unmixed blessing to the men they attended, as they drew down on themselves and their surroundings a storm of bullets wherever they went. One man, wounded in the shoulder and side, did not notice that he was shot through both legs also, until he arrived at the field hospital, and found his trousers soaked. "Didn't you notice the bleeding as you went?" was the natural question. "Lor' bless yer, Sir" he replied' "Me legs was allers behind me, and I couldn't turn round to look at 'em." Of course several men went for twelve, twenty-four hours or more before receiving any treatment at the hands of the surgeons. But the surprising thing is not the length but the shortness of time that elapsed in most cases before they were properly treated. I have a list against my cases of "hours before treatment," and the following is taken from a page at random:—"1, 2, 60, 5, 5, 14, 8, 1, 30, 10, 3, 3, 5." This does not take into account the field-dressing which was usually applied by a comrade within two or three hours. Considering the heaviness of the fire, the lack of cover, the fact that the forces for the most part were retreating, and that the resources of the hospital were taxed to the uttermost, this record is decidedly good. This list also, of course, does not include the most serious cases, many now dead, who would naturally receive first attention. Of these, wounds of the skull would take a prominent place. Mr. Makins, by the way, made an interesting remark as to head injuries. The only cases he had seen, he said, were wounds of the frontal lobe; and he concluded therefore, that wounds of any other part were nearly always immediately fatal. Mr. Makins, by the way, was saying the other day that the dust which gets in between the dressing and a wound if it is uncovered for only a minute or two at De Aar, was harmless so long as the camp was frequently moved; but this, of course, was a fearful trouble, and the hospital at De Aar has only been shifted, bodily, once as yet. Mr. Makins amputated poor old Pretorius' leg in the lower third of the thigh to-day. This is the result of a fractured patella, and the joint and surrounding tissues have been suppurating freely, since the patella was re-broken by a fall six weeks ago.

F. E. F.

WE have been asked to record that the Liebig's Extract of Meat Company have decided to place on all jars supplied on and after January 1st, 1900, an additional label, bearing the Company's initials, LEMCO, in white letters on a blue ground.

Guy's Hospital Debating Society.

THE thirty-ninth meeting of the society was held in the smoking-room on Saturday, December 2nd. Mr. W. C. C. Pakes (vice-president) took the chair.

The secretary was called upon to read the minutes. The society, in haste, deferred unanimously the reading of the minutes to a more convenient occasion.

Mr. STAMM rose to amend the rules by the addition of Rule 20:—"That any member of the committee who absents himself from two consecutive committee meetings without reasonable excuse shall cease to be a member of that committee." Mr. Thompson seconded. Mr. A. E. Pakes moved an amendment, which was not seconded. Mr. Wales moved an amendment, which was not put. The hon. secretary appealed *ad misericordiam*. "He himself would not be before them that night had such a motion been carried in the past." The motion was negatived, six voting for it.

The president read Rule 12, and briefly indicated his interpretation thereof.

Mr. H. WACHER then rose, amid loud cheers, to move:—"That the social life of England is urgently in need of reform." Into a description of his impassioned oratory it is needless now to enter. On those privileged to enjoy the intellectual treat of hearing our "secret sins" and the scandalous lapses from high standards which Mr. Wacher dealt with in alliterative and obliterative invective, a mere description would pall. A few expressions:—"Perfection synonym for monotony." "Compare *Daily News* and its atrocity-mongers with manly, inspiriting language of Dickens." "Realism not realism, really dirt." "Compare London streets with Parisian." He passed in review the tendencies of the Press, "Conversation," the "Brush," the Mutoscopes in the street, and the Drama. (Sensation). A brilliant and theatrical speech—probably the best for several years—was concluded with an eloquent reference to "cesspools," the whirlpools of society, whose every nook and cranny was filled with——*(Bell)*. Mr. Wacher then brought his speech to an end with an appeal for those poor creatures who have the "gnawing, lacerating bite of the dogs of conscience ever with them."

Mr. E. H. KITCHIN was pained and surprised; his indignant. shocked, feelings overcame him. He really loved reforms, but fancy mentioning reform as a subject of conversation at a dance. A whirlpool was not a cesspool. The stage—but no, he would not follow his rival there. (Both hands upraised in horror). (Loud cheers) All the virtues of the age, he concluded, were to be found in modern England. A very able speech.

Mr. C. R. HOWARD showed vast progress in reform from the literature of Bacon to the books of to-day. Genuine reform is now actively in progress.

Mr. C. A. D. BRYAN referred to the question of the decadence of modern novels. Marie Corelli, for instance. "Human interest" necessary to make books sell. He thought the aristocracy were at fault, and the common people look up to them for guidance. Scandal was an evil.

Mr. E. J. WALES, in a brilliant speech, quoted statistics, amid some dissent, to the effect that unfortunates were diminishing.

Mr. E. C. BEVERS insisted on having the statistics, which apparently could not be produced.

Mr. A. A. MILLER wished to protect his friend from the insinuation about whirlpool, when cesspool. He knew the contrary. A speech excellent in its matter and very witty.

There also spoke Mr. R. Thompson, Mr. Hirsch, Mr. A. E. Pakes, Mr. J. W. Steeweni, Mr. D. W. Smith, Mr. C. R. Howard, the hon. secretary, Mr. R. C. Mullins, Mr. J. T. Wrench, Mr. R. O. Bridger, Mr. A. J. Osborne, Mr. K. Black, Mr. E. I. Spriggs and Mr. S. Hodgson, Mr. Kitchen and Mr. Wacher thundered, in reply, in a very effective manner.

The motion was put to the vote—

For ...	...	...	30
Against	...	...	20

Carried by majority of 10

The best debate of a series of successful debates. The repartee on many occasions was very brilliant.

Chapel News.

The third of the series of "Religio Medici" lectures will be given by the Rev. E. F. Russell, IN THE COURT ROOM, on Monday next, at 5 p.m., as the chapel is not available owing to cleaning. Mr. Russell's subject will be, "On buying and selling the truth."

The process of cleaning is still going on in the chapel and it is uncertain when it will be finished. Last Sunday the Holy Communion was celebrated at St. Saviour's, at 6.45 and 9 a.m., and a service for patients was held in Ruth ward at 11 a.m. A similar arrangement will have to be made for Sunday next (January 21st). The daily prayers are said in the Court Room.

The Bishop of Rochester has appointed the Rev. W. H. Gregory, late of St. Paul's, Deptford, as Assistant Chaplain.

From the Gazette's Special Pathologist.

J. M. O., FISHGUARD.—The growth on blood-serum after incubation consists very largely of a micro-organism which is probably an oidium, and if so, it may be the oidium albicans, the specific organism of thrush. The Klebs-Löffler bacillus was not found.

X. Y. Z., HASTINGS.—In the absence of information as to the nature of the material and the investigation required, we have examined the (supposed) sputum for tubercle bacilli, but none could be found.

PATHOLOGIST.

Passim.

WITH the commencement of the last year of the Nineteenth Century, the GAZETTE has lost its old Committee and its old Editor. Mr. Eason, who for nearly eighteen months held the reins of management, has been forced by pressure of work to resign. The loss will be keenly felt on the GAZETTE, both on account of his own personal value, and also on account of the excellent staff which he had organised, and of which he is now the only survivor in the hospital. We wish him every success in his House Appointment, and hope his good luck will be in the ascendant during the next six months. Prosit!

THE Old Committee has ended its existence in the most dramatic manner. It has committed suicide. Many years ago, long before we had lost interest in marbles, a GAZETTE Committee was created, and this Committee made for itself a code of rules, by which its conduct was governed. One of these specified that any vacancies occurring in its numbers, were to be filled by gentlemen *elected by the Committee*. In other words, the Committee became self-elective. This method of procedure held good for many years, and no doubt was of extreme value to the GAZETTE. There was no yearly dissolution, no chaotic interregnum, and no election of popular, though possibly inefficient Committeemen. Time after time the old familiar faces turned up at the meetings, and the GAZETTE rolled steadily on into prosperity. But last year the Clubs' Union demanded representation on the GAZETTE Committee in order that we might fall more into line with the other constituent institutions. We met in Committee several times; the Clubs' Union met in Council likewise. Then bits of us met bits of them and together we drew up a new constitution, and with the attesting of this document we ceased to exist.

NOW, the GAZETTE Committee consists of two members of the Staff, two members selected by the Clubs' Union Council, the President of the Residents, the Editor, the Manager, and not less than four nor more than six members coöpted by the Committee. By this means every need is satisfied. The Clubs' Union has its representatives, and the GAZETTE has, at least, the battered remains of its old Committee. Also, it retains control of its own finances subject to a limited veto on the part of the Clubs' Union. This, indeed, is the most important feature of the new agreement. The Clubs' Union could not afford to absorb us entirely, with our liability; we, for our part, were unwilling to proceed without assurement of our financial soundness. Thus both parties are satisfied, and the GAZETTE goes on as usual.

IT will be a great boon to the hospital when we secure the control of our own electric-light. Never really good, the lighting has been lately steadily retrograding from bad to worse. We have been accustomed for some months to a sudden drop in voltage at about five in the evening—when the engineer goes to his tea—but lately we have experienced the complete cessation of electrical energy without even a preliminary aura. It is easily conceivable that the consequences of this light-failure might be very serious. On two successive evenings, the electric-light failed suddenly during an operation in the small theatre. Fortunately the condition of the patient was such that a short delay was harmless, but this is by no means necessarily the case. In the front surgery the dressers were very greatly inconvenienced. The natural difficulties of casualty work are sufficiently great without artificial augmentation.

THE system of electricity supply that will be adopted when the new engine-houses are completed, will be dual; our own generators will give current for all ordinary purposes such as lighting, motive power, etc., and at the same time, will charge a battery of accumulators for use after the dynamos are shut down for the night. A large transformer will be laid down in connection with the public mains, and it will be from this source that we shall obtain our power when any accident necessitates the stoppage of our own plant. By this means it is extremely unlikely that we shall ever be reduced to the straits in which we have found ourselves the last two or three months.

IN response to Mr. Fremantle's appeal, which appeared in our last number, we have received a donation of five shillings from Mr. Duncan Howe, and promises of sufficient financial support to enable us to send a Hodgen splint out to Cape Town. In this issue we publish two more letters from Mr. Fremantle, which are of especial interest, since they bring his narrative up to the date of the Magersfontein affair.

AT last definite sailing orders have been issued to those of our Nursing Staff who were selected for foreign service. Sister Stephen (Miss Creighton) sails next Saturday for the Cape, and Sister Martha (Miss Davidson) leaves on the same day. The Yeomanry Hospital, of which an account is given elsewhere, leaves England probably on February 3rd. Quite a large contingent of Guy's men and nurses are attached to this hospital, which will have a hearty send-off from at least one London hospital. Some of that remarkably noisy enthusiasm which is characteristic of a Rugger cup-tie might well be spared for this occasion, and the moral effect of a couple of hundred well-assorted male voices united in a discordant roar, is incalculable.

THIS naturally suggests the Students' Glee Club. This musical fraternity practices assiduously every Friday evening in the Court room at five o'clock, and on rare occasions conspires with the Nurses' Choral Society, at eight. The nature of the performances which the combined choirs contemplate has not yet leaked out. Whatever it may be, there is reason to believe that it will be very creditably produced. As far as the Nurses are concerned, they show a very considerable improvement on last year; the men, however, are still hampered by a paucity of tenors. Altos singing down and baritones singing up will not compensate for the lack of the tenor timbre which was so noticeable last year. If there is any man in the hospital with a tenor voice, the Glee Club will be very glad to see him; basses and baritones are very cheap just now, but the real natural tenor is at a great premium.

MR. F. E. WALKER left for the Cape as a "C.M.O." on the 11th instant. He has had the extremely good fortune to be attached to the Durham Light Infantry, and will in all probability be sent to the front. A small party of healthy-lunged friends bade him farewell at Waterloo in a most hearty fashion, and he carries enough good luck from Guy's to last him through a dozen campaigns. Mr. K. B. Alexander left a couple of days later for Aldershot, where he will be stationed for a short time before going South. Mr. Ingram, who qualified from here a short time since, has also received orders to sail on the 27th instant.

DURING the past few days the Externs have been billetted with the Charities, and in their absence some very necessary cleaning and painting operations have been conducted in their sitting-room. Now they are once more at home in nice clean quarters, somewhat colicy it is true, with fresh distemper on the walls, a white ceiling, and a gas-tight pendant. The table has been scrubbed and covered with oil-cloth after the most approved Lockhart pattern; the pictures have been rearranged; in fact everything has been done that could be possibly thought of—save one. Nobody has helped the poor old armchairs. Two pathetic, flattened masses of leather and horsehair serve as apologies for chairs. Until these are replaced by new material—for they are damaged beyond repair—the Externs' room can never be in keeping with its occupants. And when the new chairs do arrive certain Charities had better adopt a rigid proteid diet.

THE Externs have ever been famous for their hospitality; the traditions of the four o'clock tea have been handed from one firm to another until the meal has become as persistent as the Dressers' supper. It rests with the present lot of men, however, to inaugurate a second invitation meal at half-past ten. It has been customary for the men to prepare cocoa of an evening on returning from a case; the present firm go farther, and invite friends in to a light supper of cocoa and biscuits. Will any firm kindly start a breakfast?

MEDICAL and Dental School Calendars for the ensuing year are now ready and may be obtained either at the Medical office or from the Librarian. Men will save themselves and the Office a great deal of unnecessary trouble if they will get these calendars early. All the usual information with regard to dates of examinations, and last days for obtaining or sending in schedules, etc., will be found clearly set out on the cards.

AMONG the City Imperial Volunteers who sailed on the 13th instant, we noticed at least one Guy's man. Mr. Brailey, who commands a company in one of the Surrey Volunteer battalions, was Gazetted to a lieutenantcy in the Mounted Infantry, and sailed with his men last Saturday. Another Guy's man, Mr. J. A. Glover, is in the half company detailed by the London Scottish, but with the rank of private only. One or two others are as yet awaiting orders. By the way, it is rather a curious thing that we should have so few Volunteers among

us. One would naturally suppose in a community of able-bodied young men that a very large proportion would serve in the Volunteers in one capacity or another. The mere sporting element embodied in rifle shooting should serve as a powerful attraction. But this is not the case. There is a sneaking contempt, born of those unfit, and fostered by those too lazy to bear arms, of all things military. The sight of a rifle awakens only unpleasant memories; not a spark remains of the innate enthusiasm for anything that explodes. Years ago we had a Company of our own in the Artists' Rifles. The present Electrical department was our armoury, and the Park our parade ground. Now we can barely raise a section, and are unable to recruit in sufficient numbers to counterbalance the resignations.

MORE men certainly ought to volunteer. It is quite an easy matter for a man in his first or second year to put in the recruit drills, and once through this stage the keeping of oneself efficient requires no trouble whatever. Another incentive to volunteering should be the fact that an Inter-Hospital Challenge Cup, held by us in 1898, is competed for by teams of Volunteers each year at Bisley. It is infinitely easier for a man to get practice, ammunition, etc., when he is a Volunteer than it is for a civilian. And practice, and practice alone, will make an indifferent shot good, and a good shot brilliant.

A VERY annoying habit has been growing lately in connection with the Football teams. A large number of names, more especially in the 2nd and 3rd XV's, are regularly struck off the list on Friday night. Now this is distinctly unfair both to the team and to the Secretary. Saturday morning is busy enough at any time, and it becomes unbearably heavy when fresh men have to be found to fill vacancies caused in this unthinking manner. Every man ought to know on the Thursday whether he can play on the Saturday or not, and only considerations of the gravest importance should be his excuse for scratching after Thursday night. One very flagrant case was that of a man who scratched on the Saturday morning in order to play for another club. Such a man as this is far better out of a hospital team altogether.

THE Rugby fifteen which has, so to speak, been rather under a cloud lately, has, we trust, emerged in time for the cup-ties which begin next week. The game against the Old Leysians was a good one, but our side was patched up by including men out of their year; the forwards, however, showed much better form than they have done of late, and Louisson and Brown passed out well from the scrum. Jupp had no tackling to speak of, but stopped rushes well; he still seems to stand too far back, and is likely to get into difficulties as he has to take the ball on the bounce. The three-quarters lacked combination at first, but towards the end of the game played well together.

AT present the Hospital Chapel is in the hands of the workmen. The next of the series of medical Christianity addresses will accordingly be delivered in the Court Room and *not* in the Chapel.

DR. OGLE, in the *St. George's Hospital Gazette*, proves conclusively that the proper pronunciation of the word "angina" is "angīna," with a short "i." This need not deter those who wish from pronouncing it as they please. But whatever the pronunciation, the columns of this GAZETTE will not be open to any discussion on the subject. If anyone wishes to contradict the above statement, or support it, he had better write direct to the *St. George's Hospital Gazette*.

THE condition of the Colonnade leaves much to be desired. It is now quite impossible to realize the design of the Mosaic pavement, on account of the masking film of dark brown mud which constantly covers it. Once a week a quantity of water is squirted freely over the surface, and incidentally over the boots of the passers-by, but this has apparently little effect in removing the mud. The remedy, we think, is to be found in Lewis Carroll's "Walrus and the Carpenter," beginning at "They wept like anything to see such quantities of sand."

THE game against Croydon on Saturday last was a distinct improvement on any of the late performances of the Rugby team. Croydon were, no doubt, a much weaker side than of past years, and were handicapped by damages which Blunt sustained early in the game; but at the same time the performance was an excellent one on the part of the hospital team. The forwards played with combination, and showed a capacity for seizing opportunities afforded them which is quite a new feature; at the same time they must remember that honest

scrum work is necessary, and should not seek after try-getting until the opposing packs are thoroughly bested. Our men are clumsy still in heeling out, as the ball is apt to hang in the back rows, and then comes out with a rush which is perplexing to the half-back. Louisson passed well, and made some excellent openings for his three-quarters, and Brown played a good game, though his method of sweeping the ball along the ground from the scrum is risky against a smart opposing pair, and he is also addicted to slow lobs instead of straight sharp passes. The three-quarters showed more than usual combination, and tackled well, though Pye-Smith as a rule goes too high. Jupp, at full back, had not much to do and got some good kicks in, but on one occasion at least was too far back to take the ball before it bounced. We hope the whole team will train consistently for next Thursday's game against St. George's, who are a good lot, and are said to fancy their chance of ousting us from the position of cup-holders. There will, no doubt, be a large turn out of all years for the cup-tie, which will, as usual, be played at Richmond. May the result be satisfactory to us and our friends.

The Imperial Yeomanry Hospital.

DURING an animated discussion on the Imperial Yeomanry Corps, somebody said that the Corps should have its own proper hospital, and somebody else said why not start one. Now these somebodies were influential somebodies, and moreover, extremely capable and energetic, so that almost before the rumour of a nebulous hospital had reached the newspapers, a very real and material hospital was well on the road to completion.

From the very nature of things, such an undertaking should be of immense interest to Guy's men, while the appointment of Mr. Fripp to the senior surgeonship, brings the whole scheme within our gates, and makes us view this last development of Volunteer patriotism with the kindly eyes of a parent.

As the matter stands at present, and the project is complete save for the finishing touches, the Imperial Yeomanry Hospital will be located at, or in the immediate neighbourhood of, Cape Town. It will thus be essentially a base hospital. Accommodation will be provided for medical as well as surgical patients, and the staff has been chosen to meet any contingency that may possibly occur.

The Chief Administrator of the hospital is Colonel Sloggett, late Principal Medical Officer in Egypt, whose abilities are of the highest order. No less than three of the generals now in South Africa applied for his services on their staff; his acquisition as the head of affairs is therefore a very great achievement. The officially designated, "Senior Surgeon," is our own assistant-surgeon, Mr. Fripp, and his lieutenants are Dr. Washbourn, who is assistant-physician here at Guy's, and Mr. Raymond Johnstone, of University College. There is a curious coincidence in the appointment of Mr. Johnstone to serve with Dr. Washbourn on the hospital staff. The previous occasion on which they were associated was in the Honours Examination for the M.B. London. The men were bracketed first in First-Class Honours in Forensic Medicine, and the University pursued the unusual course of setting a special examination for these two candidates, from which Mr. Johnstone emerged with the scholarship and Dr. Washbourn with the medal.

Mr. Newland-Pedley, Senior Dental Surgeon at Guy's, and founder of our Dental School, has also been appointed to the hospital, where his well-known genius in surgical mechanics, and his skill in dealing with injuries to the jaw and bones of the face will make his services of especial value.

Assistant-surgeons have also been chosen, Mr. William Turner, of Westminster Hospital, being one of them. The relationship which these appointments will hold to the senior and second surgeonships, is nominally that which obtains between our own surgeons and assistant-surgeons, but in all probability the differentiation will be but slight.

Finally, there will be a staff of medical officers corresponding to our house-surgeons and house-physicians, and performing similar duties In all probability unqualified men in very limited numbers will be employed as dressers to the surgeons, an appointment exactly analogous to an hospital dressership. Needless to say the number of applications from medical students willing and wishing for foreign service has been great, and the allocation of posts must necessarily be a very invidious undertaking. Indeed, we have reason to believe that sufficient applications have been received from men either graduates in medicine of one of the great Universities or Fellows of the College of Surgeons, in sufficient numbers to thrice fill every post that exists or is contemplated.

As regards the nursing staff, the hospital will be much richer in nursing-sisters than corresponding institutions governed by the military authorities. The exact ratio between the two is as four to one, but of course the increase in sisters will entail a corresponding decrease in hospital orderlies, whose duties will be proportionately lightened. In this department as in the medical, the number of applications has largely exceeded the number of vacancies. Literally hundreds of fully qualified nurses and sisters from nearly every hospital and institution in England have applied for the coveted thirty-five vacancies; and the election has been a matter of the greatest difficulty, the only stipulation besides the possession of the necessary certificates and physical fitness, being that candidates should be in the Army Reserve of Nurses.

Never before in the history of army nursing, has such a huge and at the same time complete military hospital left England for foreign service as the result solely of civilian effort. The only things which the hospital is not taking with it are the site and water supply. The agents of the Imperial Yeomanry Hospital committee, now in Cape Colony, have instructions to procure, if possible, buildings for the proper lodging of patients and staff; failing this, they will procure a site within reasonable distance of water; the rest will be done from England. The consideration of what is included in this "rest" is rather appalling. In the first place, the number of patients to be accommodated is 520. This requires a *personnel* of 230 all told, so that the total strength of the settlement will be 750. It has been said that it takes all sorts of men to make a world, and this statement is well exemplified in the Yeomanry Hospital. It was realized from the first that the hospital must be prepared to meet every contingency unaided. The water supply perhaps may be difficult of access. To this end the expedition takes its own pumps, engines, and skilled attendants.

Then again, to minimize the risk of an epidemic through defective water filtration, especially large and powerful Pasteur filters have been provided in sufficient quantity to ensure the complete filtration of all water used in the hospital. A complete laundry plant for 750 persons and a big range of "sterilizers" have also to find their way to the base. In the fitting of the hospital several large firms have shown welcome generosity. The whole of the beds, representing a weight in iron alone of thirty-five tons, are the gift of the Birmingham Bedstead Manufacturing Co. Messrs. Mortlock & Osler have presented the whole of the china and earthenware required; many other firms have made presents of drugs, wines, etc.; Messrs. Burroughs, Wellcome & Co., for instance, have given six specially designed metal cases of drugs, each to the value of £30. The committee have received a complete portable electric-bell system; have had promises of telephone equipments, and also of a small generating plant for use in connection with the skiagraphic department. Here, too, the hospital is thoroughly efficient. A staff of skilled skiagraphers and photographers has been engaged, and several sets of the most recent apparatus placed in store.

In the event of proper buildings not being forthcoming, the hospital will land a sufficient number of double walled marquees or "hospital tents," with flooring, etc., and will exercise all its functions under canvas. Every bed in the wards will be fitted with mosquito curtains and the other additions for comfort in a South African summer. At the same time necessary stores will be provided in order that the hospital may be perfectly comfortable in the approaching autumn and winter.

The whole of the staff, surgeons, physicians, nurses, dispensers, engineers, etc., including a hundred orderlies, and sixty servants and cooks, will be shipped from home, and landed immediately on arrival, so that no time may be lost in getting to work. The stores, already collected to the value of £6,000, drugs, surgical appliances, etc., have been packed with a special view to rapid handling in embarking and disembarking. A very wise discrimination has been used in the selection of instruments and appliances. Only the most modern patterns will be taken, and the hospital will be probably better equipped in instruments for major operations than any British hospital extant. Ample provision is to be made for fractures, which will be treated, we suppose, according to the methods in vogue at Guy's Hospital. Messrs. Downs are supplying various splints, including a number of "Hodgens" (Guy's pattern), which apparently are unknown to the R.A.M.C. authorities, to judge from news received from the existing base hospitals.

But the hospital will not cease its work when it has provided for the bodily wants and ills of its patients. The committee have had the offer of, and have accepted, the services of a number of clerks in Cape Town, who will be lent by their employers to act as private secretaries to the patients. It is especially fitting that such a kindly offer should have been made to one of the noblest enterprises of the century, and by those who can most keenly appreciate the delights of a "letter from home."

We are unable to publish the names of the nurses and medical officers who will proceed from Guy's; the list is not as yet finally completed. The provisional date of departure is February 3rd, but this will be subject to the transport facilities, already sorely taxed.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Pathological Assistants to Surgical Registrar.—Messrs. F. G. Cross, F. G. Gibson.

Clinical Assistants in Medical Wards.—Messrs. E. A. Miller (Dr. Taylor); T. R. Beale Browne (Dr. Hale White); B. W. Moss (Dr. Perry); J. C. J. Da Silva (Dr. Pitt).

Clinical Assistants in Surgical Wards.—Messrs. H. Bentley (Mr. Howse); P. H. Ward (Mr. Lucas); H. B. Dismorr (Mr. Golding-Bird); H. G. Rashleigh (Mr. Davies-Colley).

Obstetric Dressers.—Messrs. J. A. B. Hammond, Stanley Hodgson (February 15th).

Ophthalmic Dressers.—Messrs. J. M. Brydone, G. T. Willan (Mr. Higgens) (February 1st); J. Steele Perkins (Mr. Brailey) (February 1st); L. D. B. Cogan (Mr. Higgens) (March 15th).

Surgeons' Dressers.—Messrs. T. H. B. Dobson, E. H. Kitchin, F. D. Welch, P. J. Nash, H. A. Ehrlich, D. R. T. Griffiths (Mr. Howse); F. Curtis, E. I. Claxton, G. G. Davidson, C. R. Howard, L. E. Stamm, E. C. Bevers (Mr. Davies-Colley); N. F. Ticehurst, H. S. French, H.

K. Lacey, R. P. Marshall, F. W. Sime, F. B. Manser (Mr. Lucas); P. T. Manson, R. Thompson, M. D. Wood, A. C. Osborn, R. Jimenez, R. D. Smedley (Mr. Golding-Bird).

Externs.—Messrs. F. G. Gibson, A. Pearson, D. Forsyth, J. F. Robinson, A. C. Ransford, P. W. L. Camps (February).

Pass List.

Royal College of Surgeons of England, November, 1899.

FINAL EXAMINATION FOR THE FELLOWSHIP.

J. Howell.

Royal College of Surgeons, Edinburgh, December, 1899.

EXAMINATION FOR THE FELLOWSHIP.

C. W. Booker. R. B. Stamford.

School Examinations, December, 1899.

FIRST YEAR'S STUDENTS.

ANATOMY.

(Maximum marks, 150.)

R. Felton, 141, H. H. Carter, 135, J. H. Clatworthy, 135, M. G. Louisson, 130, H. F. B. Walker, 128, G. Russell, 123, A. Leeming, 115, J. M. W. Pollard, 114. C. H. Reinhold, 113, W. T. P. Meade-King, 112, G. Hamilton, 102, A. M. Roome, 101, F. H. Wallace, 101, O. Black, 100, R. P. Rowlands, 100, C. J. S. Dismorr, 91, H. H. Jenkins, 91, R. O. Williams, 90, A. V. Maybury, 80, W. R. Searle, 79, H. D. Wyatt, 75, H. P. Costobadie, 74, G. C. F. Robinson, 73, A. R. Beaumont, 62, O. S. Norton, 61, G. H. Cheyney, 59, J. E. Spiller, 58, J. E. Prentis, 52, J. M. Barrionuevo, 50, J. H. Robinson, 49, S. K. Poole, 40, A. Shepperd, 39, L. Doudney, 38, J. A. C. Greene, 31, C. J. Docwra, 30, D. Steele Perkins, 29, M. J. Mottram, 28, T. H. Edey, 25, C. P. Harvey, 25, J. S. Francis, 19.

SECOND YEAR'S DENTAL STUDENTS.

TEST EXAMINATION.

ANATOMY.

(Maximum marks, 150.)

E. W. Corfe, 117, W. E. Meads, 100, T. Robinson, 83, F. W. Bromley, 79, H. L. Dent, 78, J. L. Wartski, 73, A. W. Aldis, 59, G. W. Ray, 58, H. N. Hillier, 55, D. H. Wallis, 55, H. S. Wright, 53, C. Hickes, 52, T. Walkington, 50, A. Drewitt, 49, V. S. Sams, 48, J. J. Jimenez, 45, P. H. Furnivall, 42, F. Morris, 42, J. H. Hinton, 41, J. W. Powell, 41, H. B. Ross, 41, H. J. Webb, 40, G. F. Knowles, 39, V. E. Turner, 39, A. H. Smith, 35, A. R. Cummings, 34, J. Bennett, 32, G. H. Aylen, 31, P. Greenwood, 31, A. B. W. Rust, 31, K. C. Ness, 29, A. M. A. Stevens, 29, W. H. Solomon, 26, R. S. Witcomb, 26, N. W. Green, 24, A. Archer, 19, W. K. Perry, 11, O. H. Dignum, 7, S. E. Pedler, 6.

FIRST YEARS' DENTAL STUDENTS.

ANATOMY.

(Maximum marks, 100.)

S. W. Iles, 87, A. H. Clogg, 83, A. H. Bell, 79, J. W. Walton, 79, J. B. Barron, 75, G. W. Badcock, 74, W. Giles, 67, E. Phillips, 67, R. Edridge, 66, W. E. Lowe, 65, G. S. H. Barnett, 65, C. Mills, 60, P. J. Reid, 58, G. H. Morris, 58, R. D. Knight, 57, R. J. Green, 56, E. H. Wyand, 55, G. F. Sargood, 54, A. H. Staple, 54, C. A. Buckell, 52, S. J. Saunders, 51, F. G. Day, 51, H. D. Griffith, 50, A. C. Stroud, 49, H. C. Visick, 46, W. E. Griffin, 45, W. H. Peatfield, 42, C. H. Mason, 41, T. A. Chignell, 40, S. Clifford, 35, W. Henderson, 32, H. J. Corin, 31, T. C. Holford, 30, J. Morgan, 30, C. D. Wood, 22, A. H. Forbes, 21, H. L. Whitlow, 13, F. R. E. Palmer, 4, E. Cock, 2.

CONJOINT AND DENTAL CLASSES TEST EXAMINATION.

JANUARY 4TH, 1900.

CHEMISTRY AND PHYSICS.

DIVISION I.—H. H. Jenkins, 67.

DIVISION II.—J. E. Prentis, 50.

DIVISION III.—G. C. F. Robinson, 47, D. Steele Perkins, 35, J. H. Robinson, 35.

DIVISION IV.—G. H. Cheyney, 33, O. S. Norton, 32, C. D. Wood, 30, W. Reeve, 26, H. Chinneck, 25, C. J. S. Dismorr, 25, S. K. Poole, 25, A. Shepperd, 20, A. V. Maybury, 15.

J. M. Barrioneuvo, 0, A. M. Benett, 0, H. P. Costobadie, 0, A. C. Dickson, 0, C. G. Docwra, 0, T. H. Edey, 0, A. W. Forbes, 0, P. F. Minett, 0, W. Morgan, 0, L. J. Patterson-Clavier, 0, W. R. Searle, 0, H. D. Wyatt, 0.

FIRST YEAR'S INTERMEDIATE M.B. CLASSES TEST EXAMINATION.

JANUARY 4TH, 1900.

ORGANIC CHEMISTRY.

FIRLT YEAR. (Maximum, 100).

DIVISION I.—H. H. Carter, 83, J. H. Clatworthy, 77, D. Isaacs, 77, R. Felton, 68.

DIVISION II.—None.

DIVISION III.—H. F. B. Walker, 43, G. H. Rees, 40, A. Leeming, 38.

DIVISION IV.—P. A. Peall, 31, M. G. Louisson, 20, A. E. F. Kynaston, 18, B. Moiser, 16, J. Cook, 0, G. H. Russell, 0, J. D. Thomas, 0.

SECOND YEAR. (Maximum, 200.)

DIVISION I.—H. S. Jones, 152.

DIVISION II.—J. Braithwaite, 128, E. G. Goldie, 128, W. E. J. Tuohy, 128, E. H. B. Milsom, 116, G. S. Robertson, 108, K. Anderson, 104, A. W. Iredell, 104, H. Tipping, 104.

DIVISION III.—E. W. Strange, 96, W. H. Cole, 88, W. F. Box, 84, P. R. Bolus, 80.

DIVISION IV.—R. Larkin, 56, M. D. Wood, 28, L. G. Nash, 20, F. Rogerson, 16.

Nursing News.

MATRON'S OFFICE.

The Head Nurses on night duty wishing to offer the Matron their congratulations on her appointment, invited her to tea in their sitting-room, on Wednesday evening, January 10th. During the evening songs and music and a most amusing recitation were given by the nurses. Each nurse wore something to represent the title of a well-known book The names of the books chosen were quite a secret, and a great deal of amusement was occasioned by the guessing of them, some being so difficult that none could solve the puzzle.

On January 11th, Nurse Frankham was transferred from Charity ward to Philip, and Probationer Morrah was appointed Head Nurse in Charity in her place.

On January 11th, Nurse G. Reeve went into Victoria for Midwifery training, and Probationer Archdale was appointed Head Nurse in Queen ward.

Notices.

ROYAL NAVAL MEDICAL DEPARTMENT.

An Examination of Candidates for entry into the Medical Department of the Royal Navy will be held on the 19th February next and following days, at Examination Hall, Thames Embankment.

Not less than Sixteen Commissions as Surgeon will be offered for competition.

The forms to be filled up by candidates will be supplied on application to the Medical Department of the Navy, Admiralty, Northumberland Avenue, W.C.

CHARLES MURCHISON SCHOLARSHIP IN CLINICAL MEDICINE.

The next Examination for this Scholarship will be held at the Royal College of Physicians of London, on Monday, the 2nd day of April, 1900, and two following days.

The Scholarship is open to any Student of Medicine who has been a registered Medical Student during a period of not less than five, and not more than seven, years at a Hospital in London or Edinburgh, recognised by the Royal College of Physicians of London, or by the Medical Faculty of the University of Edinburgh, and whether holding a Medical qualification or not.

The Examination will be conducted both orally and in writing, and will include—

(*a*) Examination of Patients, with reports on their cases.

(*b*) Questions on Pathology and Treatment, and

(*c*) Examination on Specimens.

The Scholarship is of the value of Twenty Guineas, nd is tenable for one year.

Intending Candidates are required to send in their names to the Registrar of the Royal College of Physicians, Pall Mall East, London, not later than March 19th, with evidence of the duration of their Medical Studies from the Deans of their respective Schools.

(The Examination for 1901 will be held in the University of Edinburgh.)

EDWD. LIVEING, M.D., Registrar.

Royal College of Physicians, London,
January, 1900.

Guy's Hospital Dental Society.

A MEETING of the above society took place on December 12th, at 5 p.m. In the absence of Mr. Baker, Mr. Payne, vice-president, occupied the chair. The proceedings opened with the last minutes, which were passed in the usual way. Casual communications were then presented by—

Mr. HILLIER.—(1.) Irregular eruption within the palate of the upper right central and query "temporary" laterals in a patient 18 years of age. (2.) Two supernumeraries erupted within the arch, displacing the centrals, in a patient aged 12 years.

Mr. WARTSKI.—(1.) Models of a typical V-shaped palate, with history. Arches of parents normal; deformity attributed to thumb-sucking. (2.) 2nd lower left molar, three-rooted, apices unclosed, extracted from girl aged 14 years. (3.) A four-rooted upper wisdom tooth.

Mr. DAVIS.—Models showing supernumeraries in the upper front incisor region.

The SECRETARY.— (1.) Model of a lower jaw illustrating "Tomes' Transitional Theory." (2.) Model showing left upper canine erupting in the palate, and by its root forcing that of the first bicuspid outwards and backwards.

Some observations having been passed on these cases, the Chairman produced the "Clinical" cases selected for the evening, apologising for their not being of exceptional interest owing to the great dearth of dental cases in the wards just now.

The first case considered was that of a man who had an ulcer upon his lower lip. Its nature was query tertiary syphilitic or epitheliomatous—a microscopic section pointed to the latter diagnosis. The usual iodide treatment had been attended with good results, and the general conclusion was that a tertiary syphilitic ulcer was becoming epitheliomatous here. Suggestions as to treatment were then made. Mr. Milligan thought the position typically epitheliomatous, and mentioned a V-shaped incision for radical cure. Mr. Dowsett thought the incision would be insufficient, that a radical operation would be exceedingly severe, and thought the continuance of Pot. Iod. in large doses the most suitable under the circumstances. The Chairman agreed with Mr. Dowsett, mentioning that potassium iodide had already considerably softened some secondary glands, as also the edges of the ulcer.

The second and third cases were cleft palates, one showing a recent partially successful operation, and also a hare-lip scar, and the other being as yet untreated.

The fourth and last case was that of a man with gout associated with granular kidney, gout being evidenced by his teeth. Mr. Bennett said gouty teeth, he thought, were hereditary, and he did not see how gouty teeth developed late in life could possibly affect teeth which had previously been perfect. Mr. Dowsett and the Chairman largely agreed with Mr. Bennett.

A short history was given with each case, and the members had the opportunity of examining the patients themselves. The Chairman then announced the next meeting, and the proceedings terminated.

SOME RECENT ADDITIONS TO THE DENTAL MUSEUM.

Two specimens of old French mineral teeth. Presented by Mr. W. C. Jones.

Model illustrating gemination of the upper central incisors. Presented by Mr. A. C. Edwards.

Enamel nodule in the root of a lower wisdom tooth. Presented by Mr. W. K. Perry.

False gemination of a root to a 2nd lower molar. Presented by Mr. W. K. Perry.

Model of a cleft palate. Presented by Mr. Hicks.

Cementoma connected with upper right lateral incision. Presented by Mr. P. Greenwood.

Reviews.

Medical Bristol in the Eighteenth Century. By W. H. Harsant, F.R.C.S. Eng. Being the Presidential Address delivered at the opening of the Twenty-sixth Session of the Bristol Medico Chirurgical Society.

Mr. Harsant, who is an old student of Guy's Hospital, departs from the usual trend of presidential addresses and speaks, as he himself says, "in lighter vein." He has collected a series of anecdotes of medical men in Bristol, which, perhaps, suggests more vividly than anything else the social and professional life of an eighteenth century physician. Dr. William Logan, one of the first physicians to the infirmary, "was a strict observer of professional costume, and never stirred abroad or was visible at home, unless in full dress, that is to say, his head covered by the immense flowing wig of George II's time, a red roquelaire hanging from his shoulders to his heels, his wrist graced by a gold-headed cane, and his side furnished with a long French rapier." Of Dr. Ludlow it is said, "His peruke alone was enough in itself to command respect, for it was ornamented with regular and formidable tiers of curls to the number of one hundred and ten, and was known as 'The Royal George,' in allusion to the great line-of-battle ship, then the pride of the Navy."

The surgeons were much less extravagant in dress, and apparently somewhat lacking in dignity, when compared with their medical brethren. Possibly they suffered from a too close association with the barber-surgeons who "shaved each person for twopence, cut hair for three halfpence, and bled for sixpence," besides giving "all customers who were bled two quarts of good ale, and those who were shaved or had their hair cut, a pint each." Mr. Townsend, who was surgeon to the infirmary from 1755 to 1780, "was once walking down Broad Street during an illumination, and observed a boy breaking every window which had not a light. He asked him how he dared to injure people's property in that way. 'Oh,' said the boy, 'all for the good of trade; I am a glazier!' 'All for the good of trade is it?' said Townsend, lifting his cane and breaking the boy's head, 'there then, you rascal, get that mended for the good of my trade; I'm a surgeon.'"

St. George's Hospital Gazette (2 nos).

In the November number of this Gazette appears an interesting article by Dr. Ogle, on a subject which caused considerable discussion here a short time since, namely, the correct pronunciation of "angina." It appears to be well established by competent authority that the "i" in "angina" is short.

Sport.

Rugby Football.

GUY'S v. OLD LEYSIANS.

(GUY'S, 15 POINTS; OLD LEYSIANS, NIL).

The Old Leysians sent a fairly representative team to Honor Oak Park on Saturday, January 6th, but the Hospital was without the services of Cutler, Jackson, Morgan, O'Brien and Thomas. F. C. Wetherell and F. E. Walker were, however, available, and helped not a little to secure a substantial win by 15 points to nil. Guy's kicked off from the Brockley end, and for some time play was confined to neutral ground. A good kick by Pye-Smith took the ball up to the visitors' twenty-five, and then Sime by his favourite kick and rush game, cleverly secured the ball, but came to earth just on the line; he, however, managed to roll over and secured the try, Louisson successfully taking the place-kick. After the kick-off, play was transferred to our goal, and some hot scrums were contested, while the Old Leysians were awarded a free kick for off-side tactics on the part of Louisson. The attempt at goal, however, failed, and the kick out relieved the pressure. A second try was secured in the first spell by Louisson, who was again successful with the kick.

Crossing over two goals to the good, the Hospital forwards kept up the pressure, and narrowly missed scoring on several occasions; at last, Walker, who was playing a very fine loose forward game, got in a pretty dribble, and smartly picking up, secured a try which Louisson neatly converted. Guy's continued to hold the upper hand until the call of time, and won an interesting game by 3 goals (15 points) to nil. Team :—

GUY'S.—E. N. Jupp (back); J. T. Hicks, C. D. Pye-Smith, F. C. Wetherell and F. W. Sime (three-quarter backs); M. G. Louisson and S. C. Brown (half-backs); R. C. Mullins, D. H. Trail, K. V. Trubshaw, P. T. Manson, A. H. Wall, R. C. Lawry, E. H. Milsom and F. E. Walker (forwards). Referee: Mr. T. Morgan.

GUY'S v. CROYDON.

(GUY'S 25 POINTS; CROYDON, NIL).

This match, played at Honor Oak Park on Saturday, 13th instant, attracted the usual body of Croydon supporters, who seemed rather surprised at the crushing defeat their side sustained. Kicking-off from the Pavilion end, the Croydon forwards at first proved themselves the better scrummagers, and, heeling out well, made a good opening for their three-quarters, who were, however, badly out-manœuvred, with the result that Manson scored about ten minutes from the start of play. Once again the Croydon forwards secured the ball to no purpose, as T. P. Thomas got possession of it, and, by a clever dribble and pick up, scored near the posts; Louisson easily converting. Guy's forwards were now warming up to their work, and determined to maintain their advantage, while the Croydon pack appeared to have lost heart, and were certainly handicapped by an accident to Blunt's knee early in the game. The third try was the outcome of capital play on the part of Thomas, who broke away from the line-out, and gave Manson a good pass on reaching Trollope, the Croydon back. Thomas failed with the kick, and Guy's crossed over at half-time with 1 goal and 2 tries to their credit.

The hospital team played with far more dash than they have hitherto displayed this season, and the Croydon defence was soon utterly demoralised; indeed, of the backs, Trollope was the only one who attempted any, and he had a bad time in attempting to check our forward rushes. Morgan centred well with a high cross-kick from the touch-line, and putting his men on-side, allowed Thomas to score again, but the place kick failed; and then Louisson, who throughout played a very clever attacking game, gave Morgan an opening which he made the most of by scoring in a good position, but failed with the kick as the ball struck the post. Mullins, from a forward rush was the next to score, and he soon afterwards repeated the performance, while Wall had bad luck in having what was apparently a fair try rejected by the referee. Mullins succeeded in placing one goal, but was too deliberate at the second attempt, and the ball was charged down. Having the game secure, the home side slacked off a little, and nearly let Patey in, but he managed to make a muddle of it, and Guy's eventually won by 2 goals and 5 tries to nil. Team:—

GUY'S.—E. N. Jupp (back); E. Morgan, J. T. Hicks, C. D. Pye-Smith and F. W. Sime (three-quarter backs); M. G. Louisson and S. C. Brown (half-backs); R. C. Mullins, T. P. Thomas, D. H. Trail, H. A. Cutler, K. V. Trubshaw, P. T. Manson, A. H. Wall and R. C. Lawry (forwards). Referee: Mr. E. G. Attenborough.

GUY'S "A" v. ROSSLYN PARK "A."

(ROSSLYN PARK, 28 POINTS; GUY'S, NIL).

Played at Richmond, and resulted in a win for Rosslyn Park by 2 goals and 6 tries to nil. Guy's were one short owing to one man not even taking the trouble to scratch, and very weak owing to numerous and late scratchings. The play consisted of trying to keep our opponents from scoring all the time. Bridger, at back, played fairly well, and Brown at three-quarter was useful. The remainder of the team seemed to be in a very slack condition. Team:—

GUY'S.—R. D. Bridger (back); L. Dondeney, H. T. Palmer, C. A. E. Ring, H. S. Brown (three-quarter backs); A. E. Kynaston, R. Willan (half-backs); G. Shorland, F. R. Featherstone, L. Moiser, H. M. Rendall, G. Nunn, H. Watts, M. A. Collins (forwards).

GUY'S "A" v. CROYDON "A."

(CROYDON, 10 POINTS; GUY'S, 3 POINTS).

A good game resulted in a win for Croydon by 2 goals to a try. We scored first after pressing, but after this did not seem to do nearly so well, the forwards slackening off a little. Of the forwards, Millsom, Malim, Odgers and Brayne were the pick. Both halves played up well. Team:—

GUY'S.—A. McIlveley (back); C. P. Witcomb, C. A. E. Ring, H. N. Grose, A. Tolhurst (three-quarter backs); A. E. Kynaston, R. Willan (half-backs); E. H. Millsom, N. Odgers, E. J. Malim, F. Beaumont, G. Nunn, A. W. Gater, R. E. Brayne, M. A. Collins (forwards).

AT the Annual General Meeting of the United Hospitals' Rugby Football Club, held at King's College Hospital, the following officers were elected for the season, 1899–1900. President: G. R. Turner, Esq., F.R.C.S., (St. George's); Captain: R. C. Mullins, (Guy's); Hon. Treasurer: T. Chetwood, (London); Hon. Secretary: R. B. Ainsworth, (St. George's); Committee: the officers of the Club and Messrs. R. Griffith (London), C. J. Graham (St. Mary's) and C. H. R. Coltart (Westminster).

The draw for the Cup-ties resulted as follows:—

	1st Round.		2nd Round.	Semi-final.	Final.
Middlesex St. Thomas's	Jan. 23		Feb. 5	Feb. 20	March 7.
University St. Mary's	Jan. 25				
Guy's St. George's St. Bart's	Jan. 26	St. Bart's	Feb. 6		
Westminster Charing Cross King's College London	Byes	Westminster Charing Cross King's College London	Feb. 8 Feb. 9	Feb. 22	

The matches to be played on the Richmond Athletic Ground.

Association Football.

GUY'S v. WEYBRIDGE.

(GUY'S, 2 GOALS; WEYBRIDGE, NIL).

Played on the 6th January, at Weybridge, when we were poorly represented, many men being still away.

Weybridge were weak forward, so that our defence was not severely tested, and we attacked for the greater part of the game. The Weybridge goal had several narrow shaves, but we only scored twice through Wiltshire and Barber, who both played a good game, well assisted by Dent. Weybridge failed to pierce our defence, so Guy's won by 2 goals to nil. Team :—

GUY'S.—Sub. (goal); Edey and Corfe (backs); Rust, Shepherd and Bacon (half-backs); Dent, Barber, Wiltshire, Chignell and Peall (forwards).

GUY'S v. REIGATE PRIORY.

(GUY'S, 8 GOALS; REIGATE PRIORY, 1 GOAL).

On the 13th we journeyed to Reigate and defeated a fairly good local team to the tune of 8 goals to 1, thanks mainly to the poor defence of their goal-keeper. Brydone missed his train, so we procured a substitute, who played a fairly useful game, when it is remembered that he had no studs in his boots, and that the ground was very slippery on the surface. Guy's started downhill, and attacked at once, but Reigate scored first through Bristowe; we soon equalised, and then had by far the best of the game, our opponents only making an occasional incursion into our territory.

At half-time we led by 5–1, and quickly added two more after recommencing. Kirkpatrick then came out of goal and played a great game for Reigate, doing his best to retrieve his mistakes. We scored once more after this, but our score should have run into double figures, Wiltshire once getting clear away, and then putting outside with only the goal-keeper to beat, and Barber missing an easy goal after a beautiful combined run with Wiltshire.

All our forwards played well, and of the defence, German and Edey were excellent, while Bacon and Wadson were also very good. We have only one more match before our Cup-tie with St. Bartholomew's, so it is to be hoped everyone will get fit, and make an effort to play against Ramsgate. Team :—

GUY'S.—Wadson (goal); Edey and Sub. (backs); German, Shepherd and Bacon (half-backs); Chignell, Barber, Wiltshire, Norton and Manser (forwards).

GUY'S 2ND v. MIDDLESEX 2ND.

(GUY'S, 2 GOALS; MIDDLESEX, 1 GOAL).

Played at Honor Oak Park on Saturday, January 6th, and resulted in a win for Guy's by 2 goals to 1. Guy's was poorly represented, and the game was of the poorest description. Guy's had rather the best of the game, and scored during the first half, Middlesex equalizing shortly after. In the second half, Guy's made many half-hearted attempts to score, and were unsuccessful till just before time, when Greenfield scored the winning goal. Team :—

GUY'S.—H. H. Carter (goal); A. Leeming, A. Gromitt (backs); J. V. C. Bent, D. G. Greenfield, F. Morres (half-backs); P. W. L. Camps, H. K. Lacey, P, Nash, —. Milton, —. Watney (forwards).

GUY'S 2ND v. OLD CRANLEIGHANS.

(GUY'S, NIL; OLD CRANLEIGHANS, NIL).

This match, which resulted in a drawn game, with no scoring, was played at home on January 13th. The game was even, and was much better than the last match. The forwards were not at all well together, and were very weak in front of goal. The whole team lacks dash, and will need a lot of training if we are to retain the Junior Cup. Leeming is the most improved man in the team, and has the making of a really good back. Carter played well in goal, several of his saves being very good. Team :-

GUY'S.—H. H. Carter (goal); A. Leeming, A. Gromitt, (backs); P. V. C. Bent, D. G. Greenfield, F. Morres (half-backs); H. L. Dent, H. K. Lacey, B. Rust, F. Morres, P. A. Peall (forwards).

Guy's Hospital Chess Club.

GUY'S v. ST. GEORGE'S.

This match was played in our Club Smoking Room on Wednesday, January 10th, play starting at 8 p.m. After meeting St. George's before Christmas, and winning easily by 7 to 1, we hardly expected the reverse, which, however, came. Dismorr at top board opened with Ruy Lopez, and playing a sound and very even game, won his game just within the two hours. Stewart, Kennard and Robinson each sacrificed soundness to brilliancy, and probably lost their games through their "sporting" moves. Parrott was considered rather lucky in bringing off a "stale mate." Miller won his game after a long fight opening with a "Mezio." Cohen scored his win fairly easily. The game on the last board was very even, but was lost just before the time limit (2½ hours).

The following is the table of games :—

GUY'S.		ST. GEORGE'S.	
Mr. Dismorr	1	Mr. Christian	0
„ Stewart	0	Dr. Grünbaum	1
„ Kinnard	0	Mr. Bond	1
„ Robinson	0	„ Lock	1
„ Parrott	½	„ Powell	½
„ Cohen	1	„ Rutherford	0
„ Miller	1	„ Shettle	0
„ Faulks	0	„ Morley	1
TOTAL	3½	TOTAL	4½

Birth.

PIKE.—On December 15th, at Flush Cottage, Heckmondwike, Yorkshire, the wife of Norman H. Pike, M.B., B.S., of a son.

Marriage.

HENSON—MAJOR.—On January 11th, at the Parish Church, Croydon, by the Rev. Canon Pereira, assisted by the Rev. J. Henson and the Rev. Talfourd Major, William Warner Henson, M.R.C.S., L.R.C.P., of Impendhle, Natal, son of George Henson, Esq., of Prestwold, Leicestershire, to Dorothy Wickham Featherstonehaugh Major, second daughter of the late C. M. Major, Esq., of Cromwell House, Croydon. Natal papers please copy.

ED.—S. H.

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Calendar of Coming Events.

February, 1900.

Sat. 3.—1 p.m., Clinical lecture by Dr. Bryant.
Messrs. Golding-Bird and Dunn's take-in; Drs., P. T. Manson and M. D. Wood; Cl., O. Marriott.
G.H.R.F.C., I.—Catford Bridge, away.
II.—Marlborough Nomads, home.
III.—Sidcup "A," away.
IV.—Catford Bridge IV., away.
G.H.A.F.C., I.—Ewell, home.
II.—Ewell II., away.
G.H.P.P.S.—Pathological Meeting.

Wed. 7.—1.15 p.m., Clinical lecture by Mr. Golding-Bird.
G.H.R.F.C., IV.—Dulwich College III., away.
G.H.A.F.C., I.—R.M.A., away.

Thur. 8.—Messrs. Howse and Symonds' take-in; Drs., E. H. Kitchin and P. J. Nash; Cl., A. H. Davies.
G.H.C.U.—Missionary Address.

Sat. 10.—1 p.m., Clinical lecture by Dr. Bryant.
G.H.R.F.C., I.—Kensington, home.
II.—Kensington, away.
III.—Catford Bridge II., away.
IV.—Wimbledon "A," away.
G.H.A.F.C., I.—Old Eastbournians, home.
II.—Furzedown Park, away.
Dental Society's Dinner at 6 30 p.m.

Wed. 14.—1.15 p.m., Clinical lecture by Mr. Golding-Bird.
G.H.R.F.C., II.—Merchant Taylor's Schools, home.

Thur. 15.—Messrs. Lucas and Lane's take-in; Drs., H. K. Lacey and R. P. Marshall; Cl., W. S. Stewart.
G.H.C.U.—Address by Rev. Prebendary Webb-Peploe.

Sat. 17.—1 p.m., Clinical lecture by Dr. Bryant.
G.H.R.F.C., I.—Lennox, away.
II.—Lennox, home.
III.—Blackheath Preparatory School, away.
IV.—Epsom College II., away.
G.H.A.F.C., II.—City of London School, away.
G.H.P.P.S.—"Etiology and Prognosis of Epithelioma of Tongue." By F. G. Gibson.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well a subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold will be ONE SHILLING AND SIXPENCE.

Guy's Hospital Gazette,

FEBRUARY 3, 1900.

Suppurative Pylephlebitis.

CLINICAL LECTURE BY DR. BRYANT.

January 6th, 1900.

GENTLEMEN,—Last summer when I was in charge of Clinical, a case of Suppurative Pylephlebitis, that is, suppurative thrombosis of the portal vein, was admitted under my care. I have chosen this disease as the subject of my lecture to-day on account of its rarity, the obscure nature of the symptoms, the difficulties of making a correct diagnosis during life, and the very meagre description that you will find of it in the text-books. Suppurative pylephlebitis was the post-mortem diagnosis. The case was admitted as one of right-basal lobar pneumonia, and after careful physical examination and exploratory aspiration this diagnosis was thought to be most likely right up to the time of the patient's death, although it failed to explain in a satisfactory manner certain of the physical signs which were present. A few important negative statements have been added to the notes I shall read to you, which are taken from the excellent report of the case prepared by Mr. D. P. Watson. Perhaps there are some who will read this report and say, "Why was the disease not correctly diagnosed during life?" It is easy to be wise after the post-mortem examination. We unfortunately all make mistakes in diagnosis, and we shall

continue to do so I am afraid, but we shall not fail to learn and profit by these mistakes. Do not be too ready to scoff when the post-mortem reveals a mistake in the diagnosis, endeavour to find out what points were missed, take them to heart, and apply the lessons you have learned when you are faced by similar difficulties. You will learn more from the exposure of a mistaken diagnosis than from the confirmation of a correct one. I will read you the notes of this case, will then scrutinise the symptoms and discuss the diagnosis as far as possible, as we did in the ward, and then, lastly, if I have time, I will give you an account of the disease, based on twenty cases collected from our Records.

The patient was a boy, fifteen years of age, who was admitted on August 30th, 1899, for vomiting and pyrexia. On August 22nd he went to work and seemed in his usual health. At 1 a.m. on the 23rd he vomited and complained of pain in the right side. He felt feverish but had no rigors. He had eaten some green apples before going to bed. He did not remain in bed, but as he did not improve he was taken to see a doctor, who diagnosed gastro-enteritis, and ordered him to be kept in bed on a milk diet. He was very sick again on the 28th, and as the sickness continued and he seemed worse, he was admitted on August 30th. The bowels throughout have been freely opened and the motions very loose. There has been no cough and no expectoration.

Several years ago he was treated in King's College Hospital for a tuberculous ankle, and was kept in bed for some months. He was also treated at the same hospital for some disease of the left eye, for which iridectomy was performed. Two years ago he was treated for appendicitis by the same doctor, who sent him up for admission.

Condition on admission.—Temperature 101·6°, respiration 48, pulse 120. A fairly well developed boy. He seemed rather collapsed. His face was flushed, his eyes sunken, his lips cyanosed, and his skin hot and dry.

The respirations were shallow, regular, 48. The lower part of the chest on the right side was bulged, the intercostal spaces were filled out, and this side of the chest did not move well on respiration The tactile vocal fremitus was increased over the right lower lobe behind. There was absolute dulness on the right side, from the fourth space in front, and it extended round the chest in practically a straight line, being a little lower behind than in front. On auscultation the vesicular murmur was found to be absent over the dull area in front and over the lower part behind, that is, below the ninth rib; above this there was well marked bronchial breathing, and the voice sounds were rather ægophonic in character. Above the upper limit of dulness a few medium non-consonating râles were audible. There was no cough and no expectoration.

Pulse 120, low tension and running in character. The cardiac impulse was in the fifth space in the nipple line. Cardiac dulness normal. Sounds normal.

Tongue dry and coated with brown fur. Sordes on the lips and teeth. The abdomen moved well on respiration; it was a little rigid in the upper part, and there was slight tenderness on palpation below the right costal margin. The liver and spleen could not be felt. There was no abnormal area of dulness. There was no tenderness, and no tumour to be felt in the right iliac region.

Urine 1023, dark coloured, acid. No albumen, chlorides not diminished.

The patient was thought to be suffering from lobar pneumonia of the right lower lobe, complicated by some obscure hepatic or subdiaphragmatic condition to account for the curious conformation of the right side of the thorax.

At 9 p.m. on the day of admission his temperature reached 104·6°, when he was sponged. On the 31st, at 10.30 p.m., he commenced to vomit, and the vomiting continued until 4 a.m.

On the 1st of September he was given minim doses of tincture of iodide every half hour, and the vomiting ceased. At 7 a.m. he became collapsed, cyanosed and almost pulseless. At 10 a.m. his temperature was 96°. On account of the bulging of the thorax on the right side, and the filling out of the intercostal spaces, the question of empyema, subdiaphragmatic abscess, and hepatic abscess all along had been considered, and it was deemed advisable to explore. No pus was found. Oxygen was administered, also musk and brandy, after which his condition improved for a time. Vomiting came on again, but was checked by tincture of iodide. The temperature rose to 103·6°, and patient sank and died at 10 a.m.

At the necropsy the body was found to be wasted. In the pleural cavity about a pint of clear serous fluid was found. The base of the right lung and the upper surface of the diaphragm were covered with recent lymph. The right lower lobe was quite airless from compression. There was no pneumonia. The heart weighed six ounces; it was healthy. The liver was firmly adherent to the diaphragm and to

the parts which were in relation with it. The adhesions were firm and fibrous. The liver itself was much enlarged, and its upper level reached as high as the third rib, the lower edge did not project below the costal margin, and the organ weighed seventy-two ounces, or just double what it should have weighed. *In situ* it looked as if it had been dragged upwards by means of its adhesions to the diaphragm, and possibly by actual permanent contraction of the diaphragm. It felt softer than normal, and the capsule was a good deal thickened. On section, multiple small foci of suppuration were seen, more particularly in the upper part of the right lobe, where they had run together in places. Throughout the right lobe little abscesses and collections of abscesses were seen. The left lobe was comparatively free. The portal vein and its branches contained sanious pus and ante-mortem thrombus; it was nowhere completely obstructed.

The spleen weighed four ounces, and was firmly adherent to the under surface of the diaphragm. The cause of the portal pyæmia was found in the appendix. The cæcum and appendix were bound down by firm, thick connective tissue. On making a careful dissection the appendix was found curled up in the form of the letter "O," and lying in the centre of the coil was an oval concretion which had ulcerated through the appendix, the hole in which was found. Another opening was found in the centre of the coil communicating with the cæcum, and, I take it, through this latter opening the pus of the appendicitic abscess discharged itself into the cæcum. The other abdominal viscera were healthy.

A specimen of pus was obtained from the liver for bacteriological examination, every precaution being taken to prevent the possibility of accidental contamination. Microscopical examination showed the presence of a few short bacilli; cultures showed the presence of the bacillus coli communis. No other organism was found.

I have read out rather fully the account of this case, and first of all, as I said, I will consider the symptoms and physical signs and discuss their bearing on the diagnosis. A diagnosis must be based on a very careful estimate of the significance of the previous history, of the symptoms, and the physical signs.

The first point that I have to draw your attention to is the onset: it was acute, it commenced with vomiting and pain in the right side; and it is definitely stated that, the day before, the boy went to work and appeared quite well. He was admitted on the seventh day of his illness, and died on the ninth day.

The previous illness of appendicitis is an important point to consider, and it is also of importance to take notice of the diagnosis of the doctor who sent the boy into the hospital, viz., that the patient was suffering from gastro-enteritis. When I saw him in the ward the temperature was 104°, the respiration rate was 44, and the pulse was 140. I shall draw your attention to the ratio between the pulse, the temperature, and the respiration again. The other prominent symptoms were, the vomiting, the pain in the right side, the diarrhœa, and the dyspnœa.

The general appearance of the boy was interesting. He looked very ill, he was rather collapsed, his face was flushed, his eyes sunken, his lips cyanosed, and his skin hot and dry. Of the physical signs, the shape of the chest first attracted my attention. I noticed that it was not symmetrical; the right side was bulged, was much more prominent than the left, and the spaces on this side were filled out. There was less respiratory movement on the right side than on the left. The tactile vocal fremitus was increased at the right base, and there was absolute dulness extending round the chest on the right side (*vide* Diagram). There was deficient entry of air below the ninth rib, and bronchial breathing above. There was no cough. We asked him whether he had ever had any cough or expectoration, but we could get no evidence of it.

The condition of the tongue was important; it was dry and covered with brown fur. With regard to the abdomen, it was not distended, but it was slightly rigid in the upper part. The liver and spleen could not be felt, and there was no marked tenderness. The iliac region was carefully examined, and there was no evidence of recent or old appendicitis. And then there is that statement about the urine—that the chlorides were not diminished. Those are the points on which we had to base the diagnosis, and taking all of them together we thought that the most likely one was pneumonia. But the pneumonia did not explain the bulging of the thorax or the filling out of the spaces. That is a condition which you do not get in a simple lobar pneumonia. We had to suggest something else to explain it, and we thought that it might be due to subdiaphragmatic abscess or possibly to hepatic abscess. Our chief reason for saying that it was not due to any subdiaphragmatic condition was the line of dulness.

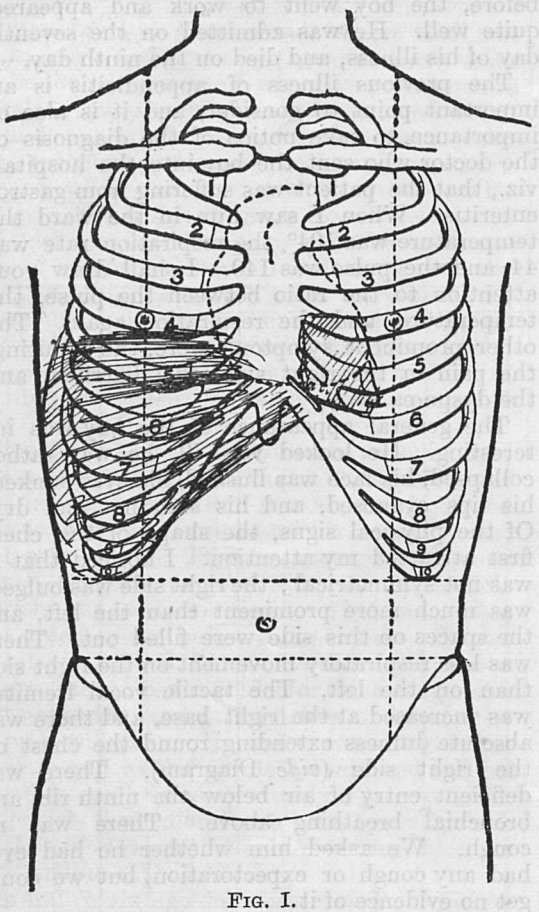


Fig. I.
Representing areas dull on percussion anteriorly.

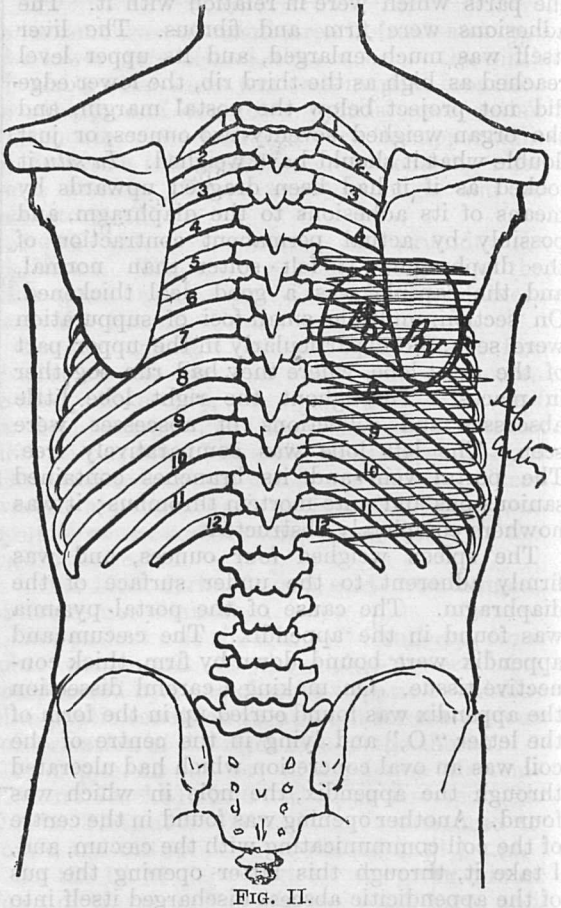


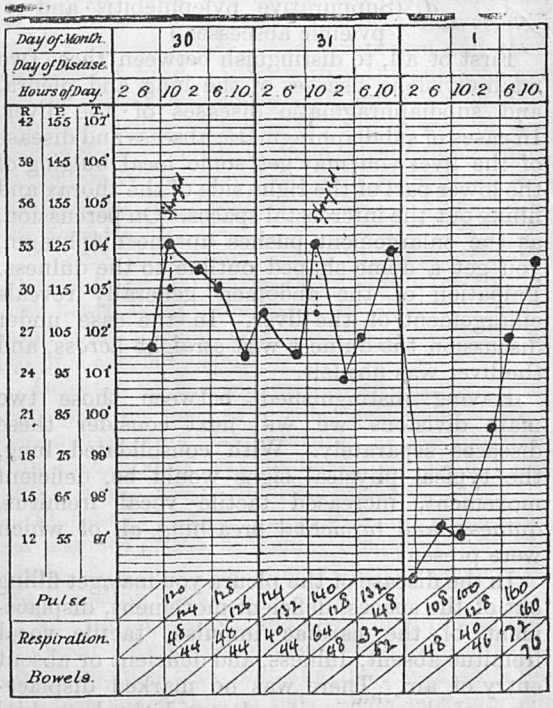
Fig. II.
The same, posteriorly.

The upper line of the dulness comes, as you will notice, straight across in front and behind. With diseases beneath the diaphragm, you get the diaphragm pushed up, and the upper outline of the dulness is in consequence arched or dome-shaped. It comes something like this (represented on blackboard). On this account we thought that the *chief* condition from which this boy was suffering was some disease of the lower part of the right side of the thorax, and, as I have already stated, we thought it was pneumonia.

I will tell you now of the points which were in favour of pneumonia. The illness started acutely with vomiting; pneumonia generally commences with a rigor, but occasionally vomiting is the initial symptom. Sometimes in pneumonia the time of the onset may be given to you by the patient. I remember seeing a patient in a clinical ward, a man, who said he started his work at six in the morning and then felt quite well. At seven o'clock he was seized with pain in the right side and shivering, and when he came into the ward he had signs of early pneumonia. So that pneumonia is a process which starts with a very acute onset. As you have already heard, this boy's illness started acutely at 1 a.m. in the morning with vomiting. He had also pain in the right side, that is another symptom you frequently find in pneumonia. On admission the temperature was 104°, the respirations were 48, and the pulse was 120. You notice the respiration rate was very much increased, and the pulse rate also was increased, and the rapid respiration rate with the abnormal signs on the right side of the chest, pointed to some disease of the lung or pleura.

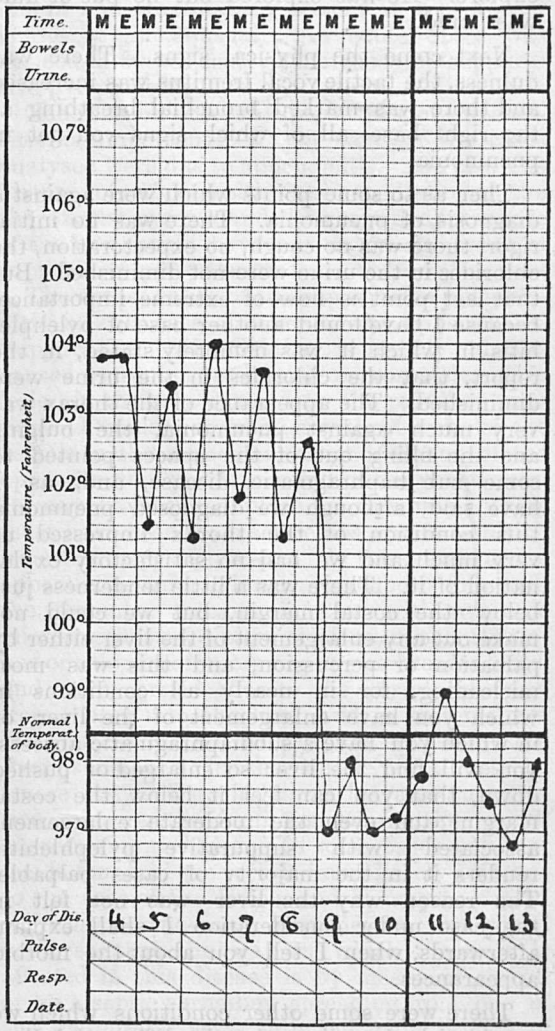
This ratio between the temperature, the pulse, and the respiration is a very important point to

remember; it is characteristic in some diseases. On the temperature charts provided by the hospital, you will see the ratio given between the respiration, pulse, and temperature; it is the physiological ratio. For instance, with a temperature at 104°, the respiration rate is 33, and the pulse 125. In pneumonia with a temperature of 104°, the respiration rate may be 40, or possibly more than that, and the pulse rate may be lower than the physiological ratio, *e.g.* 100. In typhoid fever, the ratio is also very striking in the ordinary run of cases, with a temperature of 104°, the respiration rate may be 28—the respiration rate usually depends, however, upon the amount of bronchitis present; in some cases, providing that there is marked bronchitis, the respiration rate may be over 40—and a pulse rate, which is quite low, of about 80. In very bad cases of pneumonia when there is severe toxæmia, the pulse rate may be high, 120 or more. This boy was extremely ill, and we thought that the high pulse might possibly be explained by a severe toxæmia, and so we looked upon the temperature and respiration ratio as an important sign of pneumonia. And now I want particularly to draw your attention to the course of the temperature. On the first, second, and third days, you will notice (from the chart) that it was a continuous



temperature. And on the second day of admission, that is, on the eighth day of the disease, there was a sudden drop which we thought was the crisis.

The crisis in pneumonia may come on as late as the eighth day.* When looking up our cases of pneumonia for Dr. Pye-Smith, I found that out of 316 cases 39 had a duration of 8 days. I have put up (here) also a copy of the temperature chart of lobar pneumonia, from Dr. Taylor's



book on Medicine. This is a typical chart of the course of temperature in pneumonia, and if you compare the two charts the temperatures are about the same, even to the sudden drop or

* Allbutt's System of Medicine. Vol. v.

crisis, in fact, they are practically identical. And so on the second day we thought the disease was pneumonia, and still more so on the eighth day when the sudden fall in the temperature occurred. The boy was very ill when this pseudo crisis took place, and we had to stimulate him to bring him round. At that time I thought again, as I had all along, that there was a possibility of pus being present, and I considered that it was necessary to explore. He was explored but no pus or fluid was found.

Next come the physical signs. There was dulness, the tactile vocal fremitus was increased and there was marked bronchial breathing at the right base, all of which signs you get in pneumonia.

Then as to some points which were against a diagnosis of pneumonia. There was no initial rigor, there was no cough, no expectoration, the chlorides in the urine were not diminished. But that last point is now of extreme importance, because I have found another case of pylehplebitis in which it was definitely stated, in the report, that the chlorides in the urine were diminished. The appearance of the thorax was very much against pneumonia, the bulging and the filling out of the spaces pointed to some sub-diaphragmatic disease, and, as I have said, although we diagnosed pneumonia this condition of the thorax impressed us very much and we had no satisfactory explanation of it. There was a little tenderness just below the costal margin, but we could not make out any enlargement of the liver either by *palpation or percussion, and this was most* misleading, for in nearly all conditions in which you have enlargement of the liver, or in which you have a subdiaphragmatic abscess, you will find the liver so enlarged or pushed down, that you can feel it below the costal margin, and even the moderate enlargement associated with suppurative pylephlebitis renders it in the majority of cases palpable. The reason why the liver was not felt in the case under consideration I shall explain afterwards, when I tell you about the morbid appearances.

There were some other conditions which we considered when discussing the differential diagnosis. The physical signs were at the right base of the lung, and the most important of them was dulness, so that it practically came to differentiating the various conditions which give rise to dulness at the right base.

Dulness at the right base.

A. Diseases of the lung and pleura.

1. Consolidation of the lung.
   - *a.* Lobar pneumonia.
   - *b.* Diffuse broncho-pneumonia.
   - *c.* Fibroid lung.
   - *d.* Basal phthisis.
   - *e.* Malignant growth.
   - *f.* Hydatid.
   - *g.* Large infarct.
2. Diseases of the pleura.
   - *a.* Pleuritic effusion
     - Hydrothorax
       - Bright's disease.
       - Chronic valvular disease of the heart.
     - Simple serous effusion (inflammatory).
     - Seropurulent effusion.
     - Purulent effusion.
     - Hæmothorax.
   - *b.* Thickened pleura.
   - *c.* Tuberculous pleurisy.

B. Subdiaphragmatic diseases.

1. Subdiaphragmatic abscess.
2. Certain diseases of the liver.
   - *a.* Abscess.
   - *b.* Hydatid.
   - *c.* New growth.
   - *d.* (Suppurative pylephlebitis and pyæmic abscesses.)

First of all, to distinguish between these two main divisions diseases of the lung and pleura, and subdiaphragmatic diseases of the liver. In cases of subdiaphragmatic abscess and disease of the liver you may get some local bulging of the lower part of the right side of the thorax and filling out the intercostal spaces. On percussion, as the enlargement pushes up the diaphragm, you get a dome-shaped outline to the dulness. Palpation of the abdomen generally reveals enlargement of the liver. In the case under discussion the dulness was straight across, and the liver was not felt.

Having distinguished between those two main divisions we will next consider these diseases separately. With consolidated lung, the typical physical signs would be, deficient movement, increased tactile vocal fremitus, dulness, and bronchial breathing, all of which were present.

In the disease of the pleura you may get filling out of the spaces, deficient movement, displacement of the cardiac impulse, tactile vocal fremitus absent, dulness, and deficient or absent entry of air. There was no marked displacement of the cardiac impulse and the bronchial

breathing was so loud that pleural effusion was considered unlikely.

The question of diffuse bronchopneumonia was considered, but the course of the temperature and the dulness and bronchial breathing without moist sounds were considered points very much against this view.

Fibroid lung is a disease which may come on after pleurisy or empyema, and it is often associated with bronchiectasis, but there is generally evidence of that, *e.g.*, bronchial breathing, loud râles, and the expectoration of a large quantity of sputum, especially in the early morning, sometimes as much as half a pint or more. It has not an acute onset.

Basal phthisis was considered in this case on account of the tubercular history, but basal phthisis is exceedingly rare; and, again, in this disease the bronchial breathing is associated with consonating râles, and the onset is not acute. With regard to the rarity of the disease, I have only seen one case of basal phthisis, and I think it is the only case that has been in the hospital during the last eight years.

Growth was not seriously considered on account of the acute onset and the age of the patient.

Hydatid was considered on this account. Hydatid most frequently invades the liver, and it may spread through the diaphragm and then involve the lung. In this case the enlargement of the thorax was so general, and there was no other evidence of hydatid. There was no expectoration. With hydatid of the lung there is generally hæmoptysis, and sometimes expectoration of daughter cysts, scolices, and hooklets.

A large infarct may occur in cases of heart disease, but if you look at this diagram (produced) the heart is not increased in size, the heart sounds are normal, and there is no evidence at all of a cardiac lesion.

Diseases of the pleura. With pleuritic effusion you do not, as a rule, get such a large amount of bronchial breathing as we found in this case, and it was so loud that we did not think it was due to pleuritic effusion.

Thickened pleura. That was not considered on account of the bronchial breathing being so loud. Nor was tuberculous pleurisy considered for the same reason.

And now I want to show you how it was that we went wrong in this case. The most unusual thing about it was that the liver was so large and yet could not be felt. The post-mortem showed that the liver was firmly adherent to the wall of the thorax; and I should imagine that the lower part of the liver first became attached to the thoracic wall, so that when it subsequently enlarged it could not come down into the abdomen. To show you how unusual this symptom is, of the twenty cases which I looked up, the liver was definitely stated to be enlarged in 60 per cent. of them and could in all those cases be felt below the costal margin.

Another point of similarity between pneumonia and this disease is, that an acute onset is not at all unusual. An acute onset was noticed in 60 per cent. of the cases of suppurative pylephlebitis.

The relation of a previous attack of appendicitis is important; 40 per cent. of the cases analysed were due to appendicitis. The previous history of appendicitis, the condition of the thorax, the pyrexia and the general appearance of the boy should have put us on the track of suppurative pylephlebitis.

The actual cause of the suppurative pylephlebitis in this case, I take it, was appendicitis. Suppurative pylephlebitis is nearly always caused by some suppuration or some ulcerative lesion in the area drained by the portal circulation. I could not trace any thrombosis of the vessels in the immediate neighbourhood of the appendix, but pus was found in the portal vein. It may have taken place in this way; there must have been some septic absorption resulting from the appendicitis, possibly the vessels of the appendix became inflamed, thrombosis followed, the thrombus became infected with pyogenic micro-organisms, a piece or pieces of this thrombus or colonies of micro-organisms became loose, and were carried off into the portal vein, and from thence into the liver, and in this manner little pieces of infected thrombi lodged in the liver substance, in the small portal vessels, where they set up inflammation and suppuration, causing the formation of multiple small abscesses in the liver. In some cases a thrombus is found in the vessels immediately adjacent to the seat of the lesion, and it may be traced right up to the main branches of the portal vein, so that the way in which the liver is affected in this disease is by means of emboli or by a septic thrombus spreading from one of the mesenteric veins into the main branch of the portal circulation.

The usual post-mortem appearances in cases of suppurative pylephlebitis are these:—The portal vein is not, as a rule, entirely occluded, but it contains pus and is thrombosed, and that explains why it is that you do not get ascites; ascites is a very rare condition in suppurative pylephlebitis. The liver is usually enlarged.

As I told you, in the cases which I looked up, in 60 per cent. the liver was enlarged, and it contains as a rule a number of small abscesses, and these abscesses can be traced directly to small branches of the portal circulation. The inflammation spreads to the capsule of the liver and causes adhesions between the liver and diaphragm. The spleen is sometimes enlarged, and it is not at all uncommon to find the pleura affected. I have analysed the weights of the liver; the greatest weight found was ninety-eight ounces, and the smallest forty-two ounces, the average being sixty-six ounces. In the twenty cases the diaphragm was described as being adherent to the liver in ten cases; it was stated not to be adherent in two, and it was not mentioned in the other eight cases.

No abnormal changes were noted in the heart. The spleen was enlarged in six of the cases, and its greatest weight was twenty-three ounces. Pleurisy at the right base was found in eleven of the cases; there was an effusion in five of the eleven, the effusion being purulent in three. Another condition which is sometimes found associated with pylephlebitis is peritonitis; that occurred in half of the cases.

The organisms found were, the bacillus coli communis, and in one of the cases streptococci and a bacillus; the bacillus was not identified. In one case some diplococci were found; they were also not identified. Staphylococci have been found, and in a case of dysentery the amœba coli.

And now with regard to the etiology of this disease. Eight out of the twenty cases, that is 40 per cent. of the cases, were due to appendicitis, two cases were associated with gall-stone and suppurating gall-bladder, two were secondary to gastric ulcer, one was secondary to duodenal ulcer, one was associated with empyema, one was a case of ulcer of the rectum and one a case of suppurating ovary, in two cases the cause was not found, in one case the cause was an operation for hæmorrhoids, and in one it was dysenteric ulceration of the colon. So that there are a large variety of causes even in these twenty cases. In other cases the disease has been found to be due to sloughing of the cæcum, abscess of the spleen, ulceration of the common bile duct extending to the portal vein, inflammation of the umbilical vein of infants, dysentery, and faulty operations for hæmorrhoids. Fagge described a case which was secondary to suppurating mesenteric glands, and the same authority also quotes a case of Frerich's, due to a fish-bone perforating the mesenteric vein. This disease has been known to follow also ulceration of the cervix uteri.

One of the most striking things, I think, concerning this disease is, that none of the text-books describe it as being secondary to typhoid fever, by far the commonest disease in which we get ulceration of the intestine in this country. Why it should follow on some form of ulceration and not on typhoid fever does not seem very easy of explanation. It appears very extraordinary that with such extensive ulceration of the intestine, as in typhoid fever, you never see this disease.

Then with regard to the sex of the patients, eleven cases were in males and nine in females. The ages varied from fifteen to sixty-two; the average age was twenty-nine. An analysis of the ages showed that eight of the cases occurred in the second decade, five in the third, two in the fourth, four in the fifth, none in the sixth, and one in the seventh. So that thirteen of the cases occurred in persons up to thirty years of age.

The onset was acute in twelve cases, and it was said to be gradual in two; it came on with pain in the right side in two of the cases, there was abdominal pain in two, it commenced with a rigor in three, and with vomiting in four. Pain in the back, pain in the loins, diarrhœa, acute pain in the loins; an indefinite onset sometimes with irregular chills, fever and sweating—these are the early symptoms that you may find.

It is interesting also to note for what symptoms the patients were admitted. One patient was admitted for vomiting and pyrexia, two for pain in the right side of the chest and pyrexia, one for pain in the right hypogastric region and jaundice, one for biliary colic, two for abdominal pain, and one for discharging sinus in the groin.

And then as to the symptoms of the disease. The aspect of the patient is very striking in most cases. The majority show wasting, and sunken eyes. The patients are thin, they generally have an anxious expression, some of them are jaundiced, they nearly all look very ill, some of them are restless, some are collapsed. Osler describes a "muddy complexion" as being characteristic of this disease. Many of the patients have the features of a general pyæmia.

The temperature in this disease varies considerably. The highest temperature recorded in the twenty cases which I looked up was 107° and the lowest 96°. Sometimes the temperature

is continuous and is not associated with rigors. Rigors occurred in 50 per cent. of the cases.

Then there is the relation between the temperature and pulse and respiration. Generally the pulse rate is high, so is the respiration rate, and the pulse rate is, if anything, above the physiological ratio.

Vomiting is a very common symptom, and, as I have already mentioned, occurred in 60 per cent. of the cases; and it is mentioned in the text-books also as being a most important symptom of the disease.

Diarrhœa is a common symptom, and it occurred in nine of my cases.

Constipation is noted in some of the cases, viz., in seven of them, delirium in three, jaundice in eight, that is, in forty per cent. Pepper, in his "System of Medicine," mentions that three-fourths of the cases are jaundiced. Dr. Fagge says that pylephlebitis often produces jaundice, and it does so much oftener than a single abscess in the liver.

The physical signs. The tongue is described as being dry and coated with brown fur. The abdomen is generally a little distended, and there may be some rigidity over the right hypochondriac region, some tenderness is usually noticeable in that position, and patients often complain of pain in that region. As a general rule the liver is enlarged, and if you can feel the liver it is usually tender. The enlargement of the liver is uniform in the generality of cases; occasionally you may be able to feel little soft nodules on the liver. I remember seeing, some years ago, a patient suffering from suppurative pylephlebitis, she came in with a high temperature and rigors, she was jaundiced, the abdomen was a little distended, and the liver was enlarged, the edge could be felt on a level with the umbilicus, and on its surface little nodules which were soft, and one of them which was much larger than the other fluctuated. This one was explored with a hypodermic needle, and some pus was drawn off. A diagnosis of pyæmic abscesses in the liver was made. I performed the necropsy on this case, and found portal pyæmia, pyæmic abscesses in the liver, and the cause was a suppurating gall-bladder. The gall-bladder had given way at its attachment to the liver, and just above the spot where it had perforated there was a small abscess in the liver, which had set up a general portal pyæmia.

The urine is generally normal. Albuminuria was noticed in four cases, and in those cases in which jaundice was present the urine contained bile. On the whole, the urine did not show any striking or characteristic changes.

A note, to the effect that the chest was bulged, was contained in three of the reports, so that, apparently, it is not such an unusual symptom as I thought it was. One case showed falling in of the chest, it was associated with empyema.

The duration of this disease is rather an interesting point; it is very variable—from five to 296 days. Dr. Goodhart described a case which lasted for 296 days, and in this last mentioned case signs of healing in the liver were found. The average duration, including that case, was fifty-six days, but if you exclude it, the average duration was forty-three days; the shortest was five days and a few hours. This case which I have read to you to-day was the next shortest, namely, nine days.

A correct diagnosis during life was rare. One case was diagnosed as gastro-enteritis, another pneumonia, another gall-stones and biliary colic, two as typhoid fever, one as appendicitis and hepatic abscess, and only two correctly. The diagnosis of suppurative pylephlebitis is not at all easy. The remarks I have made to-day will, I hope, help you if you ever come across this rare disease. The treatment, I regret to say, is only symptomatic. The only hope of cure would be an early eradication of the cause.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Taylor.

Mary	40.	Chronic tubercular peritonitis.
	41.	Ascites. ? Cause.
	42.	Bronchitis. Bronchiectasis.
	46.	Locomotor. Charcot's joints.
	49.	? Addison's disease.
Philip	22.	Mitral stenosis. Ascites. Compressed left lung.
	23.	Chronic Bright's disease.
	24.	Dilated stomach. ? Growth.
	25.	Left pleuritic effusion. Aspiration.
	27.	Acute transverse myelitis.
	29.	Right pleuritic effusion.
	35.	Hæmoptysis. Diarrhœa. Pyrexia. Enlarged liver.
	37.	Hodgkin's disease.
	40.	Septic endocarditis. Antistreptococcin.

Cases under Dr. Hale White.

Mary 13. Chorea.
14. Pneumonia. Mitral stenosis.
15. Pneumonia.
16. Rheumatism. ? Pericarditis.
21. Anæmia.
22. Influenza.
23. Phthisis.
24. ? Cerebro-spinal meningitis.

Philip 1. Plural effusion following influenza.
2. Acute rheumatism. Mitral regurgitation.
3. Subacute peritonitis and ascites.
4. Influenzal pneumonia.
5. Mitral regurgitation and stenosis.
6. Pneumonia.
7. Acute bronchitis. Mitral regurgitation and stenosis. Tricuspid regurgitation.
8. Dysentery.
11. Pleural effusion. Pneumonia and ?
13. Cerebral hæmorrhage. Right hemiplegia and aphasia.
14. Chorea. Mitral disease.
15. Mitral regurgitation and stenosis. Hæmoptysis.
19. Acute rheumatism.

Cases under Dr. Pitt.

Mary 26. Acute pneumonic phthisis.
27. Mitral stenosis and regurgitation. Tricuspid regurgitation.
28. Profound anæmia. Right pleuritic effusion.
29. Pyrosis with vomiting.
30. Chronic bronchitis and emphysema.
31. Chorea.
34. Hæmatemesis. Gastric ulcer.
35. Acute rheumatism.
36. Pleurisy and tonsillitis.
37. Gastric ulcer.

Cot 55. Laryngeal obstruction. Tracheotomy.

Stephen 21. Spastic paraplegia.
22. Diabetes mellitus.
23. Œsophageal obstruction. Gastrostomy.
24. Subacute appendicitis.
25. Aortic regurgitation.
26. Pneumonia. Left base.
27. Right pleuritic effusion. Drainage.
31. Chronic Dermatitis. Syphilis.
32. Chorea.
33. ? Typhoid.
34. Chorea.
37. Mitral stenosis and regurgitation. Tricuspid regurgitation.
38. Acute nephritis.

Cases under Dr. Perry.

Mary 1. Diabetes mellitus.
2. Chronic peritonitis following operation.
3. Gastritis.
4. Enterica.
6. Gastric ulcer.
7. Pernicious anæmia.
8. Gastric ulcer.
9. Abdominal tumour.
10. Chlorosis. ? Mitral stenosis.
11. Enterica.

Cot 52. Intussusception. Operation.
53. Diarrhœa.

Stephen 1. Secondary syphilis.
3. Failing heart. Pleuritic effusion. Enlarged liver.
4. ? Phthisis. ? Growth.
6. Dilated and irregular heart. Left pleuritic effusion. Bronchitis. ? Tricuspid regurgitation. ? Granular kidney.
7. Appendicitis. Operation. Stenosis of small intestine.
8. Spinal meningitis. ? Gummatous.
10. Phthisis.
11. Empyema. Displaced heart.
12. ? Ulcerative colitis.
14. Gout.
15. Rheumatic fever.
16. Laryngeal obstruction. ? Foreign body. Tracheotomy.
17. Phthisis. Eczema.
18. Pyo-pneumothorax. Tubercular.
19. Mitral stenosis and regurgitation.
20. Acute rheumatism. Aortic stenosis and regurgitation.

In the Surgical Wards.

Cases under Mr. Howse.

Astley-Cooper 22. Necrosis of tibia following compound fracture.
31. Lacerated hand.

Naaman 3. ? Iliac abscess. Operation.
5. Inguinal hernia. Varicocele. Operation.
8. Axillary sinuses. Partial fixation of shoulder-joint.
9. Cleft palate.
14. Stricture of urethra. Traumatic.
15. Keloid. Excision.
17. Thrombosed veins.
18. Septic scrotum. Removal of atrophied testis.

Dorcas 1. ? Necrosis of lower jaw.
3. Torticollis. Operation.
6. Tumour of breast. ? Involution. Cyst. ? Sarcoma.
9. Thrombosed veins.
11. ? Pneumococcal arthritis. ? Tubercular arthritis.
14. Hæmorrhoids.
16. Tubercular knee. Excision.
18. Sarcoma of right cheek. Removal.

CASES UNDER MR. DAVIES-COLLEY.

CORNELIUS	2.	Compound fracture radius and ulna through both epiphysial lines.
	4.	Fractured femur.
	8.	Hæmatoma.
	9.	Compound fracture of both tibiæ. Amputation of right leg. Comminuted fracture of right humerus, etc.
	12.	Fracture of 5th cervical vertebra.
	14.	Fractured inferior maxilla.
JOB	2.	Inguinal hernia and varicocele. Radical cure.
	3.	Stricture of rectum following a modified Kraske's operation. Cartilaginous cicatricial tissue. Excised.
	10.	Stricture of urethra.
	11.	Ectopion vesicæ. Æt. 15. Renal pelvis opened in loin.
	22.	Congenital inguinal hernia. Radical cure.
LYDIA	3.	Mastoid abscess. Operation.
	4.	Carcinoma mammæ.
	5.	Fractured femur and humerus. Nephrorraphy.
	7.	*Movable kidney. Operation.*
	10.	Temporo-maxillary ankylosis.
	11.	Carcinoma recti. Colotomy.
	12.	Goître.
	13.	Tubercular elbow. Excision.
	14.	Spinal caries.
	16.	? Tubercular kidney.
	17.	Recurrent carcinoma mammæ.

CASES UNDER MR. LUCAS.

ASTLEY-COOPER	3.	Pott's fracture.
	4.	Bullet in back. Removed.
	5.	Old necrosis of tibia. Compound fracture.
	8.	Fractured femur.
	11.	Fractured ischial ramus. Ruptured urethra. Fractured tibia. Perineal drainage.
	15.	Fractured femur.
	21.	Separated lower epiphysis of femur.
	25.	Fractured patella. Wired.
	32.	Chopart's amputation.
LAZARUS	5.	Strangulated inguinal hernia. Reduced.
	6.	Epithelioma of cheek. Excised.
	10.	Epithelioma of penis.
	15.	Ununited fracture of tibia. Screwed.
	18.	Central abscess of femur.
	19.	Strangulated inguinal hernia. Operation.
	20.	Sarcoma of testis.
MARTHA	1.	Multiple tuberculous lesions.
	2.	Congenital talipes equino-varus. Removal of wedge from outer side.
	4.	Carcinoma of rectum. Lumbar colotomy.
	5.	Lymphadenomatous glands in neck. Removed.
	7.	Strangulated femoral hernia. Operation Suture of intestine.
	15.	Rickety deformity of legs. Osteotomy of femur.
	16.	Extra capsular fracture of femur.
	20.	Scirrhus mammæ.

CASES UNDER MR. GOLDING-BIRD.

ASTLEY-COOPER	5.	Tibia and fibula.
	14.	Tibia and fibula. Wired.
	20.	Supra-condyloid fracture of femur.
CORNELIUS	5.	Burn.
	10.	Compound tibia and fibula.
	13.	Tibia and fibula. Wired.
	15.	Fractured femur.
	17.	Crushed foot. Amputation.
	18.	Fractured fibula. Amputation.
	19.	*Compound fracture right femur*; dislocated epiphysis of left femur.
	20.	Acute suppurative arthritis.
LUKE	5.	Tuberculous ulcers of leg.
	6.	Abdominal tumour.
	7.	Proptosis.
	9.	Hæmaturia.
	10.	Extravasation.
	11.	Extravasation.
	14.	Epithelioma of rectum.
	19.	False joint. Left ulnar and radius.
	20.	Tuberculous ankle.
CHARITY	6.	Sarcoma of scapula. Removal of bone.
	7.	? Tuberculous hip.
	8.	Pott's fracture.
	10.	Caries of spine.
	11.	Hammer toe.
	14.	Conical stump following amputation of femur.
	15.	Mastoid abscess.
	17.	Perinephritic abscess.
	18.	Movable kidney.
	20.	Suppurating gland in groin.
	23.	Ankylosis of elbow. ? Gonorrhœal.
	24.	Tuberculous knee.
	Cot B.	Mastoid disease.
	Cot C.	Empyema.

CASES UNDER MR. JACOBSON.

NAAMAN	20.	Retained testis. Removal.
	21.	? Vesical calculus.
DORCAS	19.	Torticollis. Operation.
	20.	Enlarged thyroid. Partial removal.
PATIENCE	2.	? Gonorrhœal synovitis. Inflammation of rectum.
	3.	Sloughing patch in left groin. ? Impetigo of upper lip.
	14.	Abscess in neck.
SAMARITAN	8.	Diabetic necrosis of great toe.

CASES UNDER MR. SYMONDS.

JOB	13.	Stricture of œsophagus. Gastrostomy.
	15.	Glands in neck (malignant). Excision.
	16.	Carcinoma recti. Excision.
	17.	Epithelioma linguæ.
LYDIA	20.	Renal calculus. Removal.
	21.	Ovarian tumour.
	22.	Goître. Excision of right lobe.
PATIENCE	4.	Tubercular glands. Excision and scraping.
SAMARITAN	7.	Ulcer of leg.
	9.	Cold abscess. Incised and scraped.

CASES UNDER MR. LANE.

LAZARUS	9.	Sarcoma of head of tibia. Amputation.
	12.	Fæcal fistula in right iliac region. Plastic operation.
	13.	Epithelioma of rectum. Colotomy.
	14.	Ventral hernia following appendectomy.
MARTHA	11.	Tuberculous breast. Removed.
	12.	Carcinoma mammæ.
	13.	Cystic disease of breast.
Cot C.		Congenital dislocation of hip.
PATIENCE	5.	Tubercular tarsus and dactylitis.

CASES UNDER MR. DUNN.

LUKE	1.	Inguinal hernia.
	2.	Varicocele.
	3.	Appendicitis.
	4.	Carcinoma ventriculi. Gastro-jejunostomy.
CHARITY	2.	? Tuberculous hip.
	4.	? Sarcoma of humerus.
	5.	Umbilical hernia. Strangulation.
Cot D.		Vesical calculus.
PATIENCE	1.	Acute suppurative arthritis.
	15.	Ischio-rectal abscess.
SAMARITAN	10.	Dog-bite. Erysipelas.
	12.	Erysipelas.

Nursing News.

MATRON'S OFFICE.

Miss Helen Lambert (Sister of Cornelius ward) has been appointed Sister of Bright ward in place of Miss Brereton who has resigned in order to join the Army Nursing Reserve for foreign service.

Sister Martha (Miss A. E. Davidson) left us on the 20th ult. for South Africa, and Miss Plummer, who was here as lady pupil in 1896–97, has returned to take charge of Martha ward *pro. tem.*

Sister Lazarus (Miss Hyland) will be transferred to Astley-Cooper when Miss Loveday leaves for South Africa, and Mrs. Lyon, who was here as lady pupil in 1896–97, will take charge of Lazarus ward *pro. tem.*

Nurse O'Neill, who has been here over four years, left us on the 31st ult., having received an appointment on the nursing staff of the Yeomanry Hospital in South Africa.

Nurse Finnemore has gone to Victoria ward for midwifery training, and Probationer A. Warren has been appointed head nurse in Miriam.

Nurse Woodward, having completed her three years' training, left on the 29th ult. for the Guy's Private Nurses' Institution. Probationer Blower has been appointed head nurse in Lazarus ward in her place.

Probationer Grassett has been appointed to fill the new post of head nurse in the surgery on night duty.

Guy's Hospital London University Club.

This Club, which is composed of Guy's men who are graduates or undergraduates of the London University, held its annual general meeting followed by the annual dinner, on Friday, January 26th, at the Café Royal, Regent Street. Dr. Pavy presided at the dinner, and was supported by twenty-three members and their friends, amongst whom were Dr. Horrocks and Mr. Tubby (vice-presidents), Drs. Adeney, Burgess, J. W. Jewell, T. D. Lister, Pye-Smith, B. A. Richmond, Savage, Spriggs, J. Tanner, and Messrs. Burghard, F. Durham, Clement Lucas, G. B. Smith, and A. H. Tubby.

Dr. Goodhart had been invited by the Committee to be the guest of the Club for the evening, but was unable to be present. Sir Samuel Wilks, Mr. Howse (president), Dr. J. H. Ga ton (who has attended every dinner since the foundation of the Club in 1889), Dr. F. Taylor, Mr. Golding-Bird and Dr. Stevenson, with many others, sent letters of regret at their inability to attend.

During the evening it was decided to send a message of farewell to Dr. Washbourn, Mr. Fripp, and all Members of the Club now departing for South Africa with the Imperial Yeomanry. C. H. F.

Papers by Guy's Men.

With Lord Methuen's Force. By Surgeon C. Marsh Beadnell, R.N.—*British Medical Journal*, 13th January.

Some Observations on the Use of Decalcified Cancellous Tissue. By W. Arbuthnot Lane, M.S.—*Clinical Journal*, 17th January.

Bacteriological Diagnosis in a School Epidemic of Diphtheria. By Kenneth W. Goadby.—*Lancet*, 27th January.

Passim.

A very strong feeling has arisen among the old dressers and ward-clerks, and indeed among all Guy's men, that some steps should be taken to express to Mr. Davies-Colley their great appreciation of the work which he has done for the hospital. We have received many suggestions from various sources, all of them excellent but none of them quite comprehensive of the sentiments which they are framed to convey. The proposal which originated from the Residents is undoubtedly the happiest; and it is this proposal which will be put into tangible form. An illuminated address, bearing the signatures of as many Guy's men, both past and present, as possible, is in process of consideration, and we hope in our next issue to publish the text and to invite all who knew and appreciated Mr. Colley, and this means every Guy's man, to send his signature on a post-card or sheet of paper, from which a reproduction will be made on the Address.

We must congratulate the Fifteen on the admirable way in which they commenced their cup-tie fight. St. George's had a big reputation, which was not confined to their immediate supporters, and the crushing defeat which they received from our men shows that we have not yet lost that capability of rising to the occasion which gained us the Cup two years ago. It was unfortunate that our success was marred by a somewhat serious accident to Pye-Smith; unfortunate for us and unfortunate for him in that he will be unable to figure in the team which, we believe, will keep the Cup in our smoking-room. We wish him a speedy recovery and hope that he will be able to be present at, if not to take part in, the final tie.

The drain still continues. As was hinted in our last number, Mr. Fripp has decided to take some unqualified dressers on the Staff of the Yeomanry Hospital. As was only to be expected there was an eager rush of men to fill the few vacancies that occurred, and there were a few happy, and many unhappy, faces returning from Curzon Street. We heartily congratulate those who have been accepted and wish them a really good time, plenty of work and a safe return.

Should they, by any chance, be fortunate enough to get to the front we have no doubt that they will keep up the already big reputation of their old school. The day at present fixed for departure is the 12th inst. It will, of course, be unnecessary to suggest that everyone who can possibly get off should turn up at Waterloo Station for a final leave-taking. The scheduled time of the train is not as yet known, but before next Monday arrives this will be common property for the asking. Several, if not all, of our Nursing Staff who have been selected will sail by the same boat. Guy's must give them a good send-off.

In view of the depletion of our Nursing Staff, several important alterations are projected. There will be several new Blues created, and a fresh distribution of cap-strings. The present Sister Lazarus will relinquish her ward and assume control over Astley-Cooper, whose Sister sails with the Yeomanry Hospital. From purely selfish motives this will be regretted by many; but what is their loss will be others' gain. The work in Astley-Cooper is immense and practically unceasing, and no one could have been chosen more capable of coping with the strain than Sister Lazarus.

The remarks which were made in the last issue of the Gazette on the singular dearth of Volunteers in the hospital have found many supporters. It is not everybody who feels that he can spare the time to make himself a thoroughly efficient fighting unit. This we freely admit. But at a large hospital such as this, there are plenty of opportunities whereby men might improve their emergency value. To many the very rudiments of drill are utterly unknown; the slight discipline which converts a mob into a force, the self-control and the self-reliance of the trained man, in fact the essential elements of a soldier, alike are wanting. And yet we possess ample material from which a really useful force might be elaborated. If a little of the time which is now perforce wasted were employed in learning such parts of infantry drill, including, of course, the use of the rifle, as every schoolboy cadet learns in his first term, we should feel that the hospital could, in an emergency, put a force of irregular troops in the field quite capable of giving a very excellent account of itself.

No one engaged in our profession can allow himself to get unfit. There is a certain end for the man who is constitutionally unstable, and in the recognition of this fact lies the importance

that is attributed in hospitals to all kinds of athletics. It may be taken, then, that we could, if necessary, as in a national crisis, put a number of men at the disposal of the authorities who were bodily fit to undergo the severities of an army in the field. Where we should be greatly deficient would be that the immense majority of the men would be absolutely devoid of discipline, and much of the time which could be spent in improving the shooting value of the men would have to be expended on simple squad drill. A number of men have proposed, as a means of remedying this evil, that squads should be formed, and that the odd hours when nothing is done, and nothing can be done, should be spent in simple infantry drill. If the idea is taken up in any numbers, and there seems to be no reason why it should not be, steps would be taken to procure arms in order that the men might become familiar with the weapons they may yet be called on to use. Patriotism, the last few months have shown, is more than a mere name to us. It remains to be seen whether we will not do all that is in our power for the Old Country.

AFTER a lapse of some years, we have been revisited with a small-pox scare. One of the house-surgeons developed a curious rash with a high temperature, and for a time was banned as a victim of the dreaded variola. Subsequently, however, he proved to have an atypical form of chicken-pox, but not before much mischief had been wrought and many fair arms scratched and inoculated. It seems, however, that there is a certain amount of small-pox about in the neighbourhood, although the hospital itself is quite free. It would be as well, therefore, for men to take the opportunity which the scare has afforded and get themselves re-vaccinated. There is plenty of lymph at hand, and it is a pity to waste it.

IN a few days' time the road in front of the Medical Buildings will assume a less chaotic appearance. The main conduit is by now nearly finished, and once the bricklayers have finished their work, the unsightly trenches will be filled up and foot traffic on a wet day once more rendered possible.

IT is too much to hope that the scattered copjes of building material will be removed yet a while. The British workman dearly loves a heap of some kind or another, and until the new buildings are completed in every detail, he will continue to keep a monument ever before us—lest we forget.

THE electric lighting shows no improvement. The sudden cessation of light when all three theatres are in full swing has now become such a constant occurrence, that the theatre staff has provided a set of lamps for use during the hours of darkness. With the present quality of the light, it is often a distinct advantage to be forced to fall back on oil lamps; the light is white and intense, and is a distinct improvement on the miserable apology which proceeds from the incandescent globes.

WE recommend the following cutting from the *Globe* to the notice of the powers in Victoria ward. Our own experience is, we confess, limited, but we have not yet experienced any great difficulty in identifying baby patients, except in the case of marasmic infants which all tend to throw back to a common simian ancestor. Here is the extract:—

> The physicians and attendants of John Hopkins Hospital, Baltimore, have hit upon a happy solution of the difficulty they have always experienced in distinguishing one young baby from another. There are, says the *New York Times*, always from one to two dozen babes in the hospital, and to the inexperienced eye they all look alike. On a small square of adhesive plaster, therefore, is written the baby's name. This plaster tag is then stuck tightly on the baby's back, just between the shoulder blades. The tag is waterproof, so it is not affected by the baths given the baby. It holds tightly until the time comes for the baby and its mother to leave the hospital, when the tag may be readily pulled off without causing the baby any pain.

SOME exception has been taken to the nomenclature adopted in our "Classified Lists of Cases." With a view to strict brevity, all unnecessary words were eliminated, and only the minimum, consistent with intelligibility, was retained. For instance, a patient in the medical wards suffering from the renal disease first described by Bright, was classified under the number of his bed with the explanatory word "Bright." This, of course, is the most compressed method of expressing the sentence "A case of renal disease similar to that first described by Bright." Our critic, however, will not admit of any compression beyond the two words "Bright's disease," and maintains that the attempt to give a disease a proper name of its own, when such name is the name of a person, is both vicious and confusing. Person-

ally we cannot agree with this view. In most sciences the names of the giants of discovery have been honoured with immortality by incorporation in the language of that science. In the electrical world, for instance, both scientific and commercial, no one speaks of "the unit of electrical current as defined and adopted by the British Association." The name "Ampère" is now used and officially recognised as implying a unit of current. In a similar manner, volt from Volta, farad from Faraday, are used to express units of pressure and capacity respectively. In our own science it is true that the one proper name sometimes expresses two diseases or abnormal conditions; for instance the word "Pott" might imply either the disease or the fracture. But this shows merely that our present nomenclature is incomplete; one of these two conditions should be re-named, and the name "Pott" left with a definite significance.

WE regret to record the death of an old Guy's man, Major Pope Walker, at Ladysmith, from enteric fever. Major Walker entered the hospital in 1879, and qualified M.R.C.S. four years later. He then went into residence at Durham University where he obtained the M.B. and M.S., and also became Licentiate in Sanitary Science in 1885. A year later he entered the Army Medical Service, where he remained until his untimely death.

WE have received a cutting from the *Cape Times* of the 28th December, which will be read with the greatest interest:—

Surgeon-Major Keenan and Surgeon-Captain Rogers did excellent work under fire, and deserve the greatest praise for the admirable manner in which they performed their humane duties of attending to the wounded. Surgeon-Captain Rogers was the last man to leave the field, and saw the Boers capturing Captain Fitzherbert. Two Boers went up to the surgeon and told him that they would not fire on the ambulance or Red Cross men. It is said, however, that they had done so several times during the battle.

Captain Rogers is a well-known Guy's man, who has recently been practising at Johannesburg with Drs. Davies and Hamilton, the latter of whom was Demonstrator of Anatomy a few years ago.

WE have received a very handsomely-produced catalogue of ventilating appliances, which is claimed by the authors, Messrs. Boyle & Co., to be, in addition, a "practical treatise on the important question of ventilation." By a series of coloured diagrams the authors endeavour to show the direction in which the ideal of ventilation must be sought. We would strongly recommend this book to the designers of our newest theatre. After a couple of hours in that gloomy place with evaporating anæsthetics, reeking antiseptics and perspiring dressers, the air becomes unbreathable, and a short spell in purer air is absolutely necessary. And this is our latest theatre, the triumph of Nineteenth Century progress in science and engineering! Not only this—we believe that other theatres are to be built on this same excellent plan on the first floor. We would implore the designers to put on macintoshes and overalls and stand in the theatre during a major operation for a couple of hours. And then we would ask them to go home and burn their plans!

ALTHOUGH the "Takes-in" maintain the usual standard of quality and quantity, the number of minor casualties attended in the front surgery shews a marked diminution. The usual Monday morning condition of affairs has lately been unknown. Twice the surgery has been empty of new cases at half-past twelve, and on last Wednesday night only one case entered the surgery between 9.20 p.m. and 12.10 a.m. It is hard to suppose that the Borough has learned cleanliness, or that husbands no longer administer correction to their wives. The only reasonable suggestion is that the war, with its stimulus to certain trades, has depleted our neighbourhood of many of its inhabitants, and that the casualties we lose are taken elsewhere.

BY now Mr. Fremantle will have received the Hodgens' apparatus for which he asked. A right and left leg trough, with pulleys, standard, etc., of the latest and most efficient pattern have been sent out to him, so that he should have no difficulty in getting an intelligent mechanic to make any number from this pattern. The cost of the splints has been defrayed by a general subscription of sixpences collected haphazard in the hospital and out. A complete list of the donors will be published in our next issue.

WE shall always be very pleased to consider any matter of interest to men who have not as

yet entered the wards. There must be much worth recording among the dissecting-room communities, but it is curious that nothing ever leaks into the columns of the GAZETTE from that source. It only wants some one to take the initiative and the thing is done. It will show a deplorable lack of enthusiasm if after this appeal we are not supplied with "copy" from the junior men.

THE popular military education which is now so frequently found in the columns of the daily press, is beginning to tell, even in our own little world. A patient, the other day, was admitted for a bullet wound in the trunk. Possibly, actuated by a confused recollection of some article on "Armies in the Field," he asked his dresser when the bullet was going to be heliographed!

THE next meeting of the Debating Society will be held this day week, Saturday 10th at 8 p.m. An impromptu debate will take place. The subject will be chosen by the Chairman or by vote from a list of subjects submitted to him by the Secretary. Anyone wishing to suggest a subject will please give it in to a Secretary (J. M. Brydone or L. E. Stamm) before 8 p.m. on the 10th. *No one* outside those who have previously promised to do so *will be called upon to speak*. Every speaker may speak twice, a first speech invariably ranking before a reply. It is hoped a large number of members will attend and make this experiment a success. It is rumoured that a vote of censure awaits the Secretary, and probably the private business will be more interesting than usual on that account, as from what we hear the attacker (and attacked?) will carry out their part with gusto.

THE Fifth Annual Dinner of the Hospital Dental Society will be given on Saturday the 10th instant, at the Criterion Restaurant. It behoves all loyal Dental Students to attend this social function of a very flourishing society. In all probability, most men will by now be in possession of tickets, but should there be any intending diners without the necessary passport, they had better communicate immediately with the Secretary, Mr. Lionel Prall. In the very nature of things, a dinner given by a Dental Society should be a gastronomic poem, an epicurean symphony. We are going.

EVERY night, when the Out-patient work is done for the day, a destructive horde of workmen ensconces itself in the Out-patient department and spends a riotous night in tearing down ceilings and splitting up walls. The only excuse they offer for this horrible conduct is the feeble one that they are employed in putting in the electric light. Of course, this does not deceive anyone for a moment. We all know that the decrepit old dynamos which wobble out the dull red glow in the theatres and surgeries, could never be asked to supply any further energy; besides, when it was asked some two years ago why the dissecting-rooms were not electrically lit, we were crushed by the all-sufficient answer that the "main" supplying the hospital was already taxed to its utmost. There is some deep-seated mystery here.

John MacLachlan.

(SHOT, CHRISTMAS DAY, 1899.)

HIS was no sudden death in gallant fight
'Mid leaden hail to hurl the foemen down,
He rushed no deep-dug trench, he seized no height
To help his friends in the beleaguered town.
No! Death approached in baser, stealthier guise—
"Be one with us" (his foemen said), "or die."
He stood untempted, with unyielding eyes,
"I will not fight my people," his reply.
Lone in their midst upon the market place,
A gallant heart of true, heroic might,
He proved his courage worthy of his race,
And gave his life for England and the right.
And now his blood cries out unceasingly
For vengeance on the dastard butchery.

N. B. B.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

NOTICES.

J. E., MIDDLESBROUGH.—Tubercle bacilli are present in the sputum in fair numbers.

J. W. S., BROADCLYST.—Reaction, acid; sp. gr., 1012; albumen, absent; blood, absent; sugar, absent. *Microscopical examination.*—The centrifugalized deposit contains numerous crystals of free uric acid, a small number of leucocytes, and many squamous epithelial cells. In spite of the absence of albumen, a very few quite definite hyaline casts were found.

PATHOLOGIST.

Notes from Dr. Shaw's Out-patients.

Among the cases attending Medical Out-patients last Friday, the following were of considerable interest.

A man, æt. 56, a stoker on board ship, had enjoyed good health, except for injuries to ribs and to a knee-joint many years ago, and for serious privation, more recently, resulting from being shipwrecked. He had no permanent ill-effects from either till two months ago, when he began to be attacked by paroxysms of shortness of breath. These usually came on at night, and compelled him to get out of bed and fight for his breath. On Christmas eve he thought he would have been suffocated. The attacks were not accompanied by cough, and rarely by thoracic pain. His appetite and powers of digestion had been impaired, and when free from shortness of breath he had felt weak and ill.

Before proceeding to examine the case, Dr. Shaw elicited for the class that paroxysmal dyspnœa such as described by this patient might have its cause in pathological conditions of the (1) lungs, (2) heart, or (3) blood.

(1) Periodical obstruction to the entry of air into the respiratory passages is seen in its most typical form in spasmodic asthma, an affection of the muscular fibres of the bronchiole, and is also a common accompaniment of bronchitis and other pulmonary diseases.

(2) Although the air might gain free admission to the smaller bronchi, the blood would not be aërated, and dyspnœa would result if the heart failed to carry the blood to or from the lungs. Organic disease of the valves or muscle of the heart is therefore a frequent cause of periodical attacks of dyspnœa.

(3) Lastly, it was pointed out that although air entry and blood movement might be perfect, faulty conditions of the blood, either deficient hæmoglobin or the presence of poisons, might, by their effect upon the respiratory centre, cause distressing "breathlessness." The commonest examples of such dyspnœa were anæmia and uræmia.

On examination the patient was found to have a very high tension pulse with thickened tortuous radial arteries. Some indistinct evidence of hypertrophy of the heart without valvular lesion and œdema of the ankles. The lungs were normal. While the urine was being examined the probabilities of the case were again discussed. The normal condition of the lungs was thought to exclude all pulmonary conditions except spasmodic asthma, which was considered unlikely on account of the age of the patient, and because the paroxysms of dyspnœa were not associated with, or followed by, cough or expectoration. The class were warned against adopting a diagnosis of asthma, a painful but not usually fatal disease, until the presence of all other causes had been carefully eliminated.

The existence of enlargement of the heart and œdema of the legs could not be considered sufficient reasons for regarding the dyspnœa as of cardiac "origin," since there was no evidence of heart failure or valvular lesion. It seemed much more probable that the large heart, thickened arteries, œdema of the legs and dyspnœa were all symptoms of Bright's disease. The clerk now reported that the urine was free from albumen and had a specific gravity of 1008. The question was then raised as to whether the absence of albuminuria was a sufficient reason for negativing a diagnosis of interstitial nephritis. It was agreed that it was not, provided that the urine was of low specific gravity, and that evidences of the usual cardio-vascular changes were well-marked. A diagnosis was therefore made of chronic Bright's disease with uræmic dyspnœa. A member of the class enquired whether it was not very unusual for uræmic dyspnœa to be the first symptom of Bright's disease to attract the patient's attention, and was told that many such cases presented themselves at out-patients, and that as a matter of fact if the modern tendency of specialism ever led to a department being set aside for the treatment of kidney disease, few cases of Bright's disease would, unaided, find their way there.

Dyspnœa, vomiting, vertigo, blindness, epistaxis, apoplexy, were by no means uncommonly the first symptoms to attract attention in Bright's disease, and more often brought a patient under treatment than urinary symptoms or renal pain.

Turning to the question of treatment of uræmia the following were laid down as the essential principles:—To lessen the amount of nitrogenous food, to endeavour to eliminate effete urinary products of the bowels and skin, and to aid the action of the kidneys by mild diuretics and abundant drinks. Rest in bed, flannel clothing, a farinaceous diet, a daily purge and a diuretic mixture were ordered. The prognosis was considered grave.

Another patient complained of a troublesome cough, dyspnœa of a few days' duration, and presented the ordinary symptoms and physical signs of bronchitis. The interest of the case lay in its probable cause. He had been treated for a similar attack last year. At that time he was engaged in a fur dyeing factory, and having given up the work on medical advice he had recovered, only to be attacked again when a few days ago he had returned to the same occupation. The probability of the bronchitis being due to dust inhaled in his occupation was being discussed when the patient joined in the discussion and urged as against this view the fact that the occupation he had followed between the two attacks, in which period he had been free from cough, was that of a tea packer, in which capacity he was much more exposed to dust. The susceptibility of certain patients to particular irritant substances was considered, and fur-pullers phthisis was mentioned. The patient explained that his special duty was to brush the fur when it was dry after being dyed, and it was thought that some particularly irritant dust might thereby be set free. It was pointed out that the persistence of such conditions led to fibroid changes in the lung, which had been called pneumo-coniosis. To avoid such an event the patient was advised, if possible, to change his occupation, and

was ordered an expectorant mixture for his immediate relief.

A little girl, aged 2, was sent up for an opinion by a medical man. The child had shown no tendency to use its legs for locomotion and seemed quite unable to sit upright. The mother said that she did not even crawl and that she was "always to be found wherever she was put." She was a seven months' child, and though delicate at first her general health was now satisfactory, except for the apparent absence of power in the back and legs. She moved her arms and was able to hold toys in her hands. The mother was anxious that some special support should be applied, and her doctor having expressed the opinion that this would be detrimental, had advised her to seek further advice on this point. On examination, the conditions described by the mother were found to exist. Dentition was well advanced and there were no signs of rickets in the bones. The fontanelle was closed. When the child was placed in the sitting posture the vertebral column as a whole was bowed forward, and if straightened, at once assumed the same contour. The legs were noticed to be voluntarily moved, the muscles were ill-developed, and the power seemed very slight. There was decided rigidity, both at the knee and ankle joints, and the mother stated that this had been much worse until she had rubbed and bent the limbs daily according to her doctor's directions. The knee-jerks were very exaggerated and slight ankle clonus could be obtained. Dr. Shaw pointed out that rigidity, increased jerks, and loss of power, almost certainly pointed to lateral sclerosis. This, a secondary condition, might have its origin in the cord or in the brain. Being bilateral one would at first suspect the cord, but the absence of any lesion of the vertebræ and the age of the child made it more likely that the essential fault was some symmetrical lesion of the motor cortical area. Such cases were clinically known as congenital spastic paraplegia, and pathologically were found to be due to an atrophic condition of the cortical cells. Congenital want of development, or injury from meningeal hæmorrhage during parturition, had both been recognised as causes. In the case before the class, want of development seemed more likely, for the child being prematurely born, labour was not likely to have been so prolonged as is usual at full term, and developmental defects would be more likely to be present.

This being the condition, the prospect of the girl ever acquiring perfect use of her legs was not hopeful, though some improvement might be expected. The use of any sort of support was strongly condemned. The best hope lay in encouraging the development of such immature cortical cells as the child might possess. The mother was advised to continue friction and passive movement of the limbs, and to place the most attractive objects just beyond the child's reach with the hope of encouraging it to make use of the few nerve cells and fibres that it undoubtedly possessed, as evidenced by the voluntary movement of its legs.

Another small child, about 4 years old, was brought up because while suffering from chorea it was attacked by swelling of its left hand and leg. There was some œdema over the wrist-joint and some effusion into the knee. There was also a loud systolic bruit at the apex of the heart. The child allowed the affected parts to be manipulated without flinching, and this absence of obvious pain made the clerk who introduced the case hesitate to regard the joint trouble as rheumatic. The child's mother, however, asserted that they had been painful, and Dr. Shaw remarked that in early childhood rheumatic affections of joints were often so slightly pronounced as to escape attention until the presence of a bruit led to a careful search for arthritis. The common association of rheumatic fever, chorea, and heart disease was well shown in this case, and the remedy ordered was a mixture of salicylate of soda and arsenic.

A man, 35 years of age, who had already been under observation without a definite diagnosis being made, was again sent up by his doctor because of the development of some new symptoms which it was thought might throw light on the case. Formerly he had complained of thoracic pain, and a loud systolic bruit had been heard over the aortic area. A provisional diagnosis of aneurysm had been made, and iodide of potassium had been prescribed. Since his last visit he had suddenly lost his voice, and had on two or three occasions expectorated a small quantity of blood, whilst his medical attendant had noticed that his left chest was dull on percussion.

The patient looked more ill than on his previous visit, and the dulness mentioned by his doctor was well marked in the lower half of his chest, whilst above there was a note so tympanitic as to raise the question of pneumothorax. The systolic bruit was still loudly audible. Dr. Shaw pointed out that while rapid accumulations of pleural fluid were rare in aneurysm they were very common in mediastinal growth, a condition which it is often very difficult to differentiate from aortic aneurysm. The sudden loss of voice and hæmoptysis might be due to either of these conditions pressing on the recurrent laryngeal nerve and involving the bronchi.

As the patient was very ill he was admitted to the hospital, it being agreed that much assistance in arriving at a diagnosis would be afforded by a laryngoscope examination and exploratory puncture of the chest.

Papers by Guy's Men.

A Case of Severe Intrauterine Hæmorrhage from Cystic Molar Pregnancy. By J. H. Targett, M.S., F.R.C.S.—*Lancet*, 20th January.

The Application of Bacteriology to Public Health. By Walter C. C. Pakes, D.P.H. Camb.—*British Medical Journal*, 27th January.

With the Army Medical Corps in South Africa.

(BY OUR SPECIAL CORRESPONDENT.)

No. 1 General Hospital,
Wynberg, Cape Town,
Tuesday, January 2nd, 1900.

THINGS are quieting down here a bit, as it is three weeks since the last battle was fought, and the hospitals near the front are almost empty. We have just sent off a batch of forty-one N.C.O.'s and men and two officers for England to-day; and are busy making up another list for shipment in a week's time or so.

In fact one of the most difficult and interesting parts of one's work here now is the prognosis of cases. The rule is that if they are not likely to be fit for duty within two months they must be sent home, unless medically unfit for the voyage. Now, "fit for duty" often does not imply that the man will be sent up to the front again, as it is by no means easy to arrange for a number of isolated units to find their proper kit and corps again. But it may have that meaning, and it at least means life under canvas on ordinary rough rations with frequent fatigue-duty, fetching and carrying, and marching under an open sun, and standing sentry through day and night in all weathers.

This practically condemns all cases of bone injury in the lower extremity, except very slight grazes or possibly a fracture of one of the less important toes. In the same way it condemns most bony injuries of the upper extremity (remembering always that these bony injuries are all compound) as the hand is unlikely to be able to grasp a rifle for long or the arm to lift heavy weights; and on active service a soldier must have no special limitations. Thus, I sent home recently a guardsman with a wound of the heel, as, although it had closed well, there would always for the present be a distinct chance of pain recurring in the scar, or in the soft tissues from pressure on the callus, preventing his doing a long day's march. In the same way I sent home to-day a man with a finger amputated at the front with subsequent cellulitis, as, although the wounds were nearly healed, and the hand felt comfortable and movement was good, one could not trust such a hand to the hardships of campaigning. Fractured humeri and other long bones of course have to go.

Visceral cases—thoracic or abdominal—practically all go home. As a rule some symptom remains from adhesions even if they do get well in the main, perhaps a little pain at the end of micturition, or on taking a deep breath; and although a few are undoubtedly so fit that they might apparently do their work perfectly well, it is safest to condemn the whole lot.

The chief difficulty, however, arises in the matter of flesh wounds. Although many of them heal within a few days of their arrival here, it requires very careful trial and study of each case before deciding whether the healed track of the bullet or the scar on the surface will or will not admit of active service within a few weeks. As a general rule, the larger the amount of scar-tissue formed, whether on the surface or in the interior of a limb, the less likely is the patient to be fit for active service. Large scars on the hands are, of course, an almost certain bar to fitness; but several cases of perforation of the hand have done perfectly well. In this way I returned to-day, as fit for duty, a man who had been shot through from the instep to the sole of the foot, apparently without obvious injury to the bones and with very little scar and no obvious adhesions; and another, shot close to the knee, from whom a bullet was extracted a fortnight ago. As a rule it is found that wounds which in our returns we are expected to sign up as aseptic can go back to work; but that where suppuration has occurred, or where much of the skin has been removed, they had best be put on the two months' list. One of my men had a large shell-wound, four inches by two inches, on his hip, and one naturally suggested grafting. But allowing a week for cleaning the wound up and three for it to heal, with the chances at the end of that time of the man still being unfit, it was officially decided for me that the bed was too precious, and that the case had best be sent back to Netley at once for the grafting to be done there. Military exigencies certainly account for many surgical sins.

The wounds, if left to themselves, appear as a rule to run a natural course and heal straight away. If they arrive from the train in a state of suppuration, it indicates apparently one of four things:—(1) bone injury; (2) retained bullet; (3) retained particles of clothing; or (4) extensive hæmatoma. The concurrent condition of this rule, except in 3, is apparently inefficient dressing. Many arrive with only the dressing on them which was applied, by an untrained hand, several hours after the receipt of the wound. Naturally, therefore, being examined here three or four days later, their wounds are often suppurating freely, and occasionally are fœtid. But you may get both a retained bullet and a fracture without any suppuration, if the dressing has been properly applied. Thus, I have a serjeant who was shot in the leg three weeks ago. The femur now has good union, the bullet is retained, but causing no trouble at present. In about a week's time we shall skiagraph the thigh and discuss the advisability of operation.

As to medical cases, one is less frequently puzzled. Obviously a case of heart disease that has escaped the medical inspection at home must be sent back again. The inspection has not seldom been done somewhat carelessly; and several men have made their journey out here for no purpose. It is equally obvious that a rheumatic or malarial patient with a history of previous recent attacks must be sent home, however completely he may recover; unless his work be sedentary, like that of our "head compounder" here, who has been under me twice for slight varying rheumatic pains. Similarly, all cases whatsoever of enteric fever, appendicitis, pneumonia, syphilis, and other serious diseases must necessarily be

put on the two months' list. Tubercle of the lung and phthisis (two distinct diseases in the army) are on a different footing, as an inclement winter is hardly desirable for them; and we generally send them with a good supply of cod liver oil to try the open-air treatment in the company of convalescent surgical cases in the "rest-camp" at Sea-Point or on Green-Point Common by the Sea, the other side of Cape Town. Some other medical man sees them there and we lose sight of them entirely.

We have had very few other chest cases, except slight idiopathic pleurisies with slight bronchitis, and these all seem to clear up well under daily painting with iodine. I have sent one persistent and robust-looking dyspeptic home after six weeks' treatment in vain, not being at all sure that he was not a malingerer. Dysentery, of which we have seen more than anything else, generally clears up within two or three weeks, most of our cases having been only subacute and treated from the first. Campaigning soon finds out illness. One man was so run down that he had to be sent home after a very long bout of six weeks or so; but I can remember no other instance. In such a case, a sea-voyage is said to be a most effectual restorative.

The difficult cases to judge of are those of S. C. F. (simple continued fever, another military disease), which are generally considered to be vaguely malarial; and of the more definite attacks of malaria proper or of subacute rheumatism, with a history of only one or two previous attacks perhaps two years ago.

On the whole the rule is that all doubtful cases be condemned.

It may be interesting to know that 3,000 patients have now passed through the 600 odd beds in this hospital.

The Duke of Portland's ambulance has arrived with Messrs. Bowlby, Tooth, and Crawford(?), of Bart 's, and Wallace of St. Thomas.'s. We have also had the pleasure of several visits from two first-rate German army-surgeons, attachés to the army here, who did four weeks' work at De Aar and the front, actually taking on some of the work at the field-hospitals. Our system does not differ much from their own now, and they appear to have been very genuinely favourably impressed by our arrangements.

F. E. F.

Reviews.

Dental Microscopy. By A. Hopewell Smith, L.R.C.P. Lond., M.R.C.S. Eng., L.D.S. Eng.; Demonstrator in Dental Microscopy, the London School of Dental Surgery; formerly Lecturer in Dental Surgery, National Dental Hospital; and Assistant Demonstrator in Microscopy, Charing Cross Hospital Medical School. Second Edition. 200 pp. 10s. 6d. net. (The Dental Manufacturing Company, Ltd.)

We have read the last edition of the above work very carefully and we congratulate the author on the successful result of his labours. As a book on methods in purely Dental Microscopy it is the best work extant; but still, looking at it from the point of view of the novice, there are in our opinion several drawbacks to it. For example, on page 27, in the paragraph to show dentine and cementum, a method of softening the tissues is described, but nothing is said as to what has to be further done to show the two tissues when the specimen is softened. Again, on page 29 the reader is told to observe the primary and secondary curves of the dentinal tubes in Human-dentine but no particulars are given as to the direction in which the section must be cut; from the text it would be inferred that all sections of dentine would show both conditions or either, which in the majority of cases they would not do. On page 30, in Human Cementum, the student would infer from the text that Salter's lines and Sharpey's fibres are seen in every section, whereas it is the exception to see them. Schreger's lines in enamel are seen by reflected light, and unless the student is told that he must examine specimens by this method, we could excuse him being sceptical of their presence if he only looked for them by the aid of transmitted light, which in all probability he would do.

The diagrams at the commencement of the book are excellent, and if used in connection with some text-book on Dental Anatomy the student would be able to grasp the different facts better than without them; unfortunately, diagrams only are given, and in order that the student should know what he is likely to expect when he has attained some proficiency in microscopy, we would suggest that photo-micrographs of the specimens from which the figures are drawn should be placed alongside for comparison.

We are pleased to see that the author recognises the advantages of using celloidin as an embedding material for frail tissues. In our opinion, celloidin is the best method at present known, and if the embedded specimen is surrounded with gum and frozen, sections can be cut from it quite as easily as when embedded in gum alone. In all decalcified specimens with tooth pulp and dentine, or tooth and absorbent organ, or tooth and periodontal membrane, the parts are much more likely to remain in situ when embedded in paraffin or celloidin, as these substances can be mounted with the specimens. To embed the foregoing decalcified tooth and soft tissue in gum alone, then, when the latter has been removed it very often happens that the different parts of the section separate. However carefully the soft parts are hardened and the hard softened, it rarely happens that the two are of equal consistency.

We should also like to suggest that at the end of the next edition the author should give a list of books of reference, so that the student, having mastered the work, may go further afield, and in such list the "Microtomist's Vade Mecum," by A. Bolles Lee should not be omitted.

A Manual of Surgery. By Charles Stonham, F.R.C.S. Eng. In three volumes. (Macmillan & Co.)

This is a general surgery text-book published presumably to replace the old three volume Treves, which is

now out of print. The first volume deals with general Surgery, the second with Injuries, and the last Regional Surgery. The first two volumes are priced at 7s. 6d. net, the third at 10s. 6d. net.

Volume I.—The author opens with Degeneration, and not, as is usual, with Inflammation, and so emphasizes what is so often neglected in text-books of this kind. The term 'degeneration' is used so loosely as a rule that it is well to define what is meant and to distinguish between true degeneration and mere infiltration with some new product. Lardaceous disease is described under the head of Albuminoid Degeneration. Calcareous infiltration is given as a cause of osteo-malacia, and as due to an excess of lime salts in the blood. A very clear and concise account is given of the phenomena of phagocytosis with the views of the rival schools of Cohnheim and Metchnikoff in the chapter on bacteriology in relation to surgery. Chapters on Inflammation, Surgical Infective Diseases and Tumours are to be found in this volume. The last chapters on Deformities, most of the illustrations being by Mr Tubby, includes spina bifida, hare-lip, cleft palate, and the malformations of the rectum, anus, and genito-urinary tract, as well as those affections generally described under the heading of Deformities.

Volume II.—With the exception of the first chapter, and one on amputations, this volume is confined to injuries. The first chapter, on antiseptic surgery, is good as far as it goes, but leaves one with the feeling that it advocates proceedings which are not very thorough or complete. Doubtless it describes the author's usual method of procedure, and probably works well enough when in practice, but in teaching beginners it is best to insist on the most scrupulous care. Nothing is said about the surgeon's dress or that of the dressers. Special mention must be made of the chapter on "Injuries to the Eye," written by Mr. Donald Gunn. This is quite exemplary in its accomplishment, being just what is wanted in a book of this kind, without attempting a discursive treatise on the whole of ophthalmic surgery in the space of some thirty pages as is so often done. The treatment of injuries to the eye, from "something in the eye" to serious perforating wounds involving the lens and vitreous, is very clearly and accurately put. The means and aids to examination, the reasons for the use of certain drugs, and the attitude of mind which a surgeon ought to assume in considering the question of sacrificing an eye, are all put before the student, and should dispel that fallacy that every perforating wound necessitates the removal of the eye. None of these cases demand an *immediate* excision, and many an eye has been saved by skilful treatment that would otherwise have been lost by excessive haste.

Volume III.—The third volume, which is the largest of the three, and is printed on thinner paper, is devoted to Regional Surgery. It suffers from being too condensed. There is material omitted which ought to have found a place, and much which could be well dispensed with, as, for instance, the chapters on ligature of arteries in continuity, injuries and diseases of the ear, and surgical diseases of the female genital organs, which should have been left to books dealing specially with those subjects. More space should have been given to the diseases of brain and spinal cord, hernia and diseases of the breast. It is a book for junior students, and it is one we can confidently recommend. The printing is good and large, the paper and finish excellent, and the illustrations on the whole are up to the average. With regard to the matter of illustrations in medical text-books, it is a great pity that in these days of improved methods of illustrations our books should be so miserably and inadequately illustrated. In numbers of old books the illustrations, although not numerous, were always worth inspecting, and invariably were inserted for a purpose. We were casually looking through Holden's Anatomy, a book published in 1855, and the contrast strikes us forcibly. Take, for instance, the picture on page 112, vol. I., in the work under review, supposed to represent a malignant pustule. This is supposed to be of such excellence that, forsooth, it has been obtained from other sources and bears the name of Follin under it. Anyone who has seen an anthrax pustule would find it hard to imagine anything more unlike it than the print inserted here; and, also, what could a student learn from such illustrations as fig. 142, vol. III.? We would draw the attention of the publishers to these facts, and to point out that it is not the multiplication of illustrations that is wanted so much as that the illustrations shall be so presented that the student learns from them what could not so easily be taught him in any other way. The more illustrations the better, but not useless and indefinite ones. In Mr. Stonham's book, however, we find few that are useless, and many that are clear and of value, and it is not as a criticism of this work that we offer these remarks, but as a protest to the general tendency in many medical books.

Experiments on Animals. By Stephen Paget, with an Introduction by Lord Lister. (Fisher Unwin.) 6s.

This account of theories developed and established as facts by experiments upon animals, written in a calm unemotional style, is the best possible way of enlightening the ignorance of many, who, for want of a knowledge of the subject, have been easily influenced by the hysterical fanaticism of anti-vivisectionists. When those who have been so ready to decry and suppress all such investigations compare with our present-day antitoxin treatment the treatment of King Charles II. in 1685, who was given as a "more generous cardiac" Lapis Goar, which was a dust of topaz, jacinth, sapphire, ruby and other jewels, made up into a pill and polished, and realise that this wonderful progress has only been made possible by these experiments, they must see how untenable their position is.

But quite apart from its controversial value, a book that tells the story of Pasteur's patient work on Rabies, Haffkine's Preventive Treatment of Cholera, and the heroic work he did with it in India, and the discovery of

the antitoxin against Diphtheria, must be one of absorbing interest, alike to the student of medicine and to the more general public.

In the first part of the book the author deals with the work done in physiology; the second, which takes up the subject from a more medical point of view, gives chapters in the story of the brilliant advance made in pathology, bacteriology, and therapeutics during recent times—altogether a survey which is very comprehensive. It is books of this character that broaden the views even of the untrained scientific mind, and prepare it for the reception of the discoveries still to be arrived at.

J. A. H.

The Broadway has a very good cartoon of Mr. Stonham as The White Knight. Many men will remember him up at the College, and will read with interest a supposed clinical lecture by him in which his brusque style is very cleverly imitated.

The Clinical Journal (January 17th) contains, among other papers, "Some Observations on the Use of Decalcified Cancellous Tissue." By W. Arbuthnot Lane.

Also received: Treatment. The Medical Temperance Review. London Hospital Gazette. The Stethoscope. The Pathology of Infective Endocarditis (by J. W. Washbourn, M.D., F.R.C.P. St. Thomas' Hospital Gazette. The Polyclinic. The Owens College Magazine. St. Mary's Hospital Magazine. The Clinical Journal.

Pass List.

Final Conjoint Examination, January, 1900.

MEDICINE, SURGERY AND MIDWIFERY.—*A. H. Davies.

MEDICINE AND SURGERY.—*C. A. D. Bryan.

MEDICINE AND MIDWIFERY.—*H. B. Foster.

SURGERY AND MIDWIFERY.—A. A. Smith.

MEDICINE ONLY.—H. J. M. Barker, *H. N. Clarke, C. Edwards, *R. Fell, *O. Marriott, L. C. Martin, A. G. Osborn, *W. R. E. Williams.

SURGERY ONLY.—J. Atkins, H. V. Bagshawe, C. H. Brangwin, E. I. Davis, *H. Durbridge, R. W. B. Hall, E. A. Longhurst, *B. W. Moss, E. J. Tongue.

MIDWIFERY ONLY.—H. Braund, E. W. Goble, T. T. Kelly, G. Lewin, P. H. Ward.

* Denotes completion of examination.

Second Conjoint Examination, January, 1900.

A. J. Beadel, L. H. Moiser, C. M. Murray, J. D. Pearson, F. M. V. Smith, F. J. Turner.

First Conjoint Examination, January, 1900.

PART I.—(CHEMISTRY AND PHYSICS.)—R. D. Bridger, F. W. Cooper, J. A. C. Greene, C. S. Morris, M. J. Mottram, W. S. Orton, J. E. Spiller.

PART II.—(PRACTICAL PHARMACY.)—R. G. Anderson, C. H. Denyer, E. W. Goble, H. T. Palmer, A. P. Piggot.

PART III.—(ELEMENTARY BIOLOGY.)—A. R. Beaumont, O. Black, F. W. Cooper, H. P. Costobadie, J. S. Francis, J. A. C. Greene, S. W. Iles, C. Lamb, C. S. Morris, L. J. Patterson-Clavier, E. C. Peers, G. C. F. Robinson, Richard P. Rowlands, J. E. Spiller.

FOUR YEAR'S REGULATIONS.

PART I.—(CHEMISTRY.)—A. E. Rowlett.

PART II.—(MATERIA MEDICA.)—K. W. Goadby.

Royal College of Surgeons of England, January, 1900.

LICENCE IN DENTAL SURGERY.

PRELIMINARY SCIENCE EXAMINATION.

W. E. Griffin.

Sport.

Rugby Football.

GUY'S v. ROSSLYN PARK.

(ROSSLYN PARK, 14 POINTS; GUY'S, 3 POINTS).

The Hospital was represented in this game, on the 20th ultimo, by what was considered the prospective Cup-Tie team, and a close game was anticipated; but the Park proved much the stronger lot, and won by 1 goal and 3 tries, to a try. The ground was greasy, and very heavy, and the light very bad owing to the fog.

Soon after the kick-off by Thomas, the visiting forwards got the ball away from the scrum, and Goudge passed smartly to Swaby; our full back had not extricated himself from the pack, and Sime by an error of judgment failed to get back in time; Morgan made a good attempt to avert a score, but was unsuccessful, and Pooley easily converted. Harrison and Morgan put in some good work, which, with a free-kick, took the game to the opposing line, and Sime, by good following up, scored; Thomas took the kick, but no goal resulted. A succession of close scrimmages followed in the Park twenty-five, and it looked as if our forwards would score, but the visitors gradually cleared, and attacked in turn; O'Brien relieved, and at half-time we were 5 points to the bad.

On restarting, the visitors again pressed, and Hood scored, but Pooley failed to convert. Our backs were again soon in difficulties owing to wretched tackling, and it was only by a good piece of play by Morgan, aided by luck, that a further try was not gained. Our forwards now rushed down well into the Park twenty-five, but Sime failed to gather a rather difficult pass when a score seemed certain. Goudge, Hood, Swaby, and Bailey did some effective passing, which ended in the last-named again scoring, but Pooley again failed with the kick. Morgan made a good run along the line, and the Hospital

pressed for a time, but Todd relieved with a fine kick, and though our men showed to greater advantage towards the end of the game they were unable to decrease their opponents' lead, and an interesting game ended in their favour to the extent of 1 goal 3 tries to 1 try. Team:—

GUY'S.—E. M. Harrison (back); F. W. Sime, E. Morgan, C. D. Pye-Smith, and A. O'Brien (three-quarter backs); M. G. Louisson and S. C. Brown (half-backs); R. C. Mullins, D. H. Trail, T. P. Thomas, H. A. Cutler, P. T. Manson, K. V. Trubshaw, R. C. Lawry, and A. H. Wall (forwards).

GUY'S v. ST. GEORGE'S.—CUP-TIE.

(GUY'S, 29 POINTS; ST. GEORGE'S, NIL).

Played at Richmond in windy, rainy weather. The game was started at 3-12, Guy's playing against the wind. From the start the game was even, the forwards seemed fairly evenly matched, but at first the play was wild and haphazard. Sime and Morgan were prominent individually of the outsides; Trail and Manson forward in some loose rushes. As the game settled down, and the team warmed to their work, it was obvious that we were smarter forward, and even against the wind did most attacking. Several scrums were formed in the George's twenty-five. The forwards had now made up their minds to win; playing with great dash, and using their feet well, they completely overcame the opposition. Thomas, Mullins and Trubshaw were prominent in several dribbles, while Louisson and Morgan were several times attacking. The attack succeeded, Thomas scoring from a rush about twenty minutes from the start; Morgan made a good attempt to convert.

On resuming, the forwards played splendidly, setting a great pace, wheeling, rushing, and using their feet in sound old-fashioned style they carried all before them, absolutely paralysing the defence for about ten minutes, and in quick succession Morgan scored twice. The game began to be rather rough, Pye-Smith was rolled over through clinging too long after a brilliant round of passing. Trubshaw and Thomas both showed up well in the loose. The game now underwent a distinct change, St. George's playing up with great energy, and the game was if anything in their favour to half-time.

After half-time the game was, on the whole, in our favour for some time, St. George's fighting a losing game with great energy, but towards the end the long lead told, and as their efforts relaxed, individual performances increased our score. First Louisson, whose dodgy active play had been the best part of our outside attack, slipped over from a scrum in their twenty-five, which was easily converted. Then Manson was conspicuous in a dribble. Brown had a drop at goal; then Louisson had a drop. Pye-Smith retired hurt, and Cutler and Thomas were both out of the scrum, the latter to replace O'Brien, whose nose was broken. St. George's were also one short, also from a broken nose occurring before half-time. The game was now over, and the loss of one forward made no difference to the continuous pressure we exerted in the closing stages. Wall dashed up and scrambled over. Cutler, amid terrific cheers and loud laughter, dropped a smart goal. Trubshaw broke through brilliantly, and unselfishly transferred to Manson, who scored on the right, and finally Lawry fell on the ball on the left; Louisson converting. We thus won by 3 goals (1 dropped) and 5 tries to nil.

The game was won, as all hard fought games are, by the superiority of our forwards, and the splendid way they used their superiority and kept going throughout. Not an imposing lot, they to a man work hard, and their foot-work and finish in following-up and tackling are undoubtedly superior to the average Guy's team. They are likely, unless out-weighted, to do well, but there is if anything a want of actual weight in tight scrums. As so often, the hardest working genuine scrummagers are little conspicuous, but Mullins and Trail were the backbone of nearly every scrum, and all the forwards showed up at different times. Thomas, Manson and Trubshaw were most conspicuous in the loose. The half-backs were small, smart and active; O'Brien and Morgan the best of the three-quarters. Harrison had little to do at back, but did well.

St. George's were rather disappointing. Tucker is at all events less formidable outside than inside the scrum, and they missed his weight badly. Their whole team seemed to lack precision, their tackling broke down badly at one time, and their outsides were too reluctant to fall on the ball, the only safe way of stopping rushing forwards. Their forwards were outplayed, but worked nobly the second half. All said, we were lucky to win by so large a score, as until the last quarter of an hour there was not so great a difference between the teams as the score would indicate. Team:—

GUY'S.—E. N. Harrison (back); T. Morgan, F. W. Sime, A. B. O'Brien, C. D. Pye-Smith (three-quarter backs); H. G. Louisson, C. Brown (half-backs); R. C. Mullins, T. P. Thomas, K. V. Trubshaw, D. H. Trail, P. T. Manson, H. A. Cutler, A. H. E. Wall, R. C. Lawry (forwards).

Referee: G. H. Harnett (Kent County).

HARLEQUINS v. GUY'S.

(HARLEQUINS, 5 POINTS; GUY'S, 3 POINTS).

Our men were naturally somewhat off owing to the Cup-tie of the preceding day, and an oddly constituted team did well to suffer no worse defeat from a fairly representative Harlequins team than five points to three. The Harlequins kicked off, but Guy's forwards, playing vigorously, took the game into their territory, and pressed for some time. Well on in the first half good combination on the part of the home backs ended in Merritt scoring a try, from which Cumberlege placed an easy goal. Guy's worked hard to equalise, and were rewarded by a try which Thomas, playing three-quarter, obtained, but Morgan was unable to improve. On crossing over, the game was very even, but a heavy, soft ground, and a greasy ball, were not conducive to first class play, and told greatly on our forwards, so that though we

frequently attacked we were unable to avert defeat by a goal to a try. Team :—

GUY'S.—E. M. Harrison (back); T. P. Thomas, E. Morgan, C. T. Hilton, J. T. Hicks (three-quarter backs); S. C. Brown, H. A. Cutler (half-backs); R. C. Mullins, D. H. Trail, A. Wall, A. R. Thompson, M. A. Collins, R. C. Lawry, E. Milsom, R. G. Anderson (forwards).

GUY'S 2ND XV. v. STREATHAM.

(GUY'S, 9 POINTS; STREATHAM, NIL).

Played at Honor Oak, on Saturday, 27th January.

The Hospital team won by 3 tries to nil, which were scored by Odgers, Brown, and King. All played up, but especially Malim amongst the forwards. Team :—

GUY'S.—R. Bridger (back); H. S. Brown, C. H. Reinhold, C. A. E. Ring, H. N. Grove (three-quarters); —. Jarvis, A. E. Kynaston (half-backs); E. J. Malim, A. W. Gater, G. Nunn, H. Watts, —. Beaumont, N, Odgers, R. Brayne, L. Doudney (forwards).

GUY'S 4TH XV. v. STREATHAM III.

(STREATHAM, 6 POINTS; GUY'S, NIL.)

Played at Streatham Common on January 20th. A good game, in which Steele-Perkins and Gater were especially prominent, resulted in the defeat of Guy's by 2 tries to nil. We should put a better team in the field, if men would avoid scratching late on Saturday, especially when no adequate reason for this step is forthcoming. Team :—

GUY'S.—D. W. Smith (back); D. Steele-Perkins, A. M. Tollhurst, J. J. Gardiner, G. H. Russell (three-quarter backs); L. Doudney, P. F. Minett (half backs); A. W. Gater, A. C. Greene, G. H. Teall, R. P. Marshall, R. O. Williams, J. W. Powell, R. Felton, sub. (forwards).

Association Football.

GUY'S 2ND XI. v. OXTED AND DISTRICT.

(GUY'S, 3 GOALS; OXTED, 1 GOAL).

The 2nd XI. journeyed to Oxted last Saturday, January 27th, and defeated a team representing Oxted and District by 3 goals to 1. Lacey and Roberts were absent from the forward line, and this no doubt helps to account for their lack of combination; individually, however, they played a fair game, Dent being seen several times to advantage at outside right. All the scoring was done during the first half, Guy's having much the better of the play. The game had to be stopped twice, as both Greenfield and Rust were hurt, but, however, neither had to retire. In the second half our misfortune pursued us. Morris' knee went, and he had to retire. Oxted played up well towards the end of the game, but were, however, unable to add to their score. Leeming, at back, was certainly not up to his usual form. With the cup ties so near at hand, and the Cup to be kept in the Smoking Room, it is certainly time that the team was getting well together, and men must remember that this can only be done by their playing regularly. Team :—

GUY'S.—E. T. Heap (goal); E. Corfe, A. Leeming (backs); J. W. Gromitt, D. G. Greenfield, F. Morris (half-backs); H. L. Dent, P. W. L. Camps, J. M. Brydone, B. Rust, P. A. Peall (forwards).

GUY'S 2ND XI. v. WOODFORD ALBION.

(GUY'S, 4 GOALS; WOODFORD ALBION, 1 GOAL).

Played at Honor Oak Park on Saturday, January 21st. The ground was in very bad condition owing to the recent rain. The hospital won easily, 4 goals to 1. Sharpe (2), Lacey (2). Team :—

GUY'S.—H. H. Carter (Goal); E. F. Corfe and A. Leeming (backs); P. C. V. Bent, W. E. Greenfield, A. V. Smith (Half-backs); H. D. Dent, L. Sharpe, H. K. Lacey, F. Morris and P. A. Peall (forwards).

Appointments.

CIVIL.

JONES, CHARLES STURGES, M.R.C.S. Eng., L.S.A., has been re-appointed Medical Officer of Health for Chichester.

LEADER, HAROLD, M.B., has been appointed House Physician to East London Hospital for Children and Dispensary for Women, Shadwell, London, *vice* Percy S. Blaker, resigned.

MANBY, E. P., M.D. Camb., M.R.C.S., D.P.H., has been appointed an Officer on the Staff of Medical Inspectors by the Local Government Board.

NEVINS, J. E., M.B. Lond., M.R.C.S., has been appointed Medical Officer for the Workhouse, Liverpool.

SUTTON, C. R. ARNOLD, M.D. Camb., has been appointed Medical Officer for the Seventh Sanitary District of the Bromley Union, *vice* F. Shapley.

THOMAS, JABEZ, F.R.C.S. Eng., Ty-Cerrig, Swansea, has been appointed by the Secretary of State for the Home Department to act as a Medical Referee under the Workmen's Compensation Act, 1897, for the Neath Division of County Court Circuit No. 31.

NAVAL AND MILITARY.

Staff-Surgeon E. R. D. FASKEN has been appointed to the *Medusa*, and Surgeon Cyril Shepherd to the *Nile*.

Lieut.-Colonel W. A. MAY, R.A.M.C., has been appointed principal Medical Officer to the 8th Division for service in South Africa.

Lieutenants J. MATTHEWS and C. R. EVANS, R.A.M.C., have sailed for South Africa.

Surgeon-Major W. Culver JAMES, M.D., F.R.C.S. Eng., Honorable Artillery Company of London, late Army Medical Reserve of Officers, is re-appointed with the rank of Surgeon-Major.

Birth.

BUSTEED.—On January 21st, at Ellesmere, Shropshire, the wife of John Hancock Busteed, L.R.C.P., L.R.C.S., L.S.A., of a daughter.

ED.—S. H.

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Calendar of Coming Events.

February, 1900.

Sat. 17.—Messrs. Lucas and Lane's take-in; Drs., H. K. Lacey and R. P. Marshall; Cl., W. S. Stewart.
1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I.—Lennox, away.
II.—Lennox, home.
III.—Blackheath Preparatory School, away.
IV.—Epsom College II., away.
G.H.A.F.C., II.—City of London School, away.
G.H.P.P.S.—"Etiology and Prognosis of Epithelioma of Tongue." By F. G. Gibson.
Mon. 19.—1.15 p.m., Clinical lecture by Mr. C. Lucas.
Wed. 21.—1.30 p.m., Clinical lecture by Mr. Symonds.
G.H.R.F.C., IV.—Merchant Taylor's School, III, away.
G.H.A.F.C., II.—Banstead, home.
Thur. 22.—Messrs. Golding-Bird and Dunn's take-in; Drs., A. C. Osborn and R. Jiminez; Cl. C. T. Hilton.
G.H.C.U.—Address by Dr. Harford Battersby.
Sat. 24.—1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I.—R.I.E.C., away.
II.—R.I.E.C., home.
IV.—Lewisham A., away.
G.H.A.F.C., I.—Beckenham, away.
II.—Beckenham 2nd XI., home.
Mon. 26.—1. 15 p.m., Clinical lecture by Mr. Targett.
Wed. 28.—1.30 p.m., Clinical lecture by Mr. Golding Bird.
March.
Thur. 1.—Messrs. Jacobson and Fripp's take-in.
G.H.C.U.—Annual General Meeting.
April Appointment List opened.
Sat. 3.—1 p.m., Clinical lecture by Dr. Taylor.
G.H.P.P.S.—Pathological Meeting.
G.H.R.F.C., II.—Streatham, away.
III.—Southwark A., away.

Guy's Hospital Gazette,

FEBRUARY 17, 1900.

On Convulsions.

CLINICAL LECTURE BY Dr. PITT.

October 28th, 1899.

(*Continued*).

Gentlemen,—I thought to-day it would be convenient to try and put before you as far as possible typical pictures of—(1) epilepsy, (2) hysteria, (3) Jacksonian epilepsy and convulsions. Of course attacks vary; and sometimes you may have great difficulty in differentiating them. But typical attacks have certain characteristics which it is essential that you should know, and they can generally be classified without much trouble. Supposing, however, that a person has an attack of epilepsy which culminates in hysteria, then it is extremely difficult, unless you have the opportunity of seeing several attacks at their onset, to feel certain with what you are dealing. But these cases are rare; and generally the characteristics are sufficiently obvious to enable you to make the correct diagnosis.

We commenced to discuss epilepsy in the last lecture, but I will reiterate some of the more important features. The typical attacks of Epilepsy begin in a certain number of cases with a shrill cry; and unconsciousness almost at once ensues. This is a valuable point of distinction. In an attack of hysteria the patient may shout during the whole of the attack. The shriek made in epilepsy is at the onset. In the majority of cases the attack is preceded by an aura, a mental or sensory disturbance which is more or less constant and gives the patient a momentary warning, before he loses consciousness, that an attack is going to ensue. This commences with a tonic spasm, which generally causes the patient to fall violently on the ground, due to the spasm of the muscles which hold the body erect; but this is not absolutely essential, as the patient may have time to sit or lie down. The tonic spasm almost invariably begins more markedly on one side than the other, and the fit is associated with deviation of the head and eyes to that side. It may commence with tonic spasm of the arm or face, but it very quickly becomes a universal tonic spasm. Jacksonian epilepsy begins with a localised clonic spasm; but the typical epileptic attacks are tonic spasms, commencing locally and very quickly

becoming universal. The deviation of the head and eyes to one side at the onset, when it occurs, may be explained anatomically by the fact, that the blood supply to the two sides of the brain is often unequal, and consequently one side of the brain may be rather more irritable than the other. The tonic spasm lasts from five to forty seconds, and when it affects the bladder, the urine is involuntarily ejected, and very often the fæces. At the end of a few seconds the patient becomes cyanosed in consequence of the tonic spasm of the muscles of respiration, and the face becomes livid. The heart still beats, but the radial pulse very often disappears owing to the spasm of the vessel. At the end of half a minute the spasm relaxes, but soon recurs, and a series of contractions and relaxations take place, so that clonic spasm results. This clonic spasm lasts one to two minutes, seldom exceeding that, sometimes less, occasionally lasting only a few seconds. With the clonic spasm, there is a tendency for the tongue to be moved about, and not infrequently to be pushed to one side, generally to the side on which the convulsion commences, and at this time the tongue is very liable to be bitten. There is violent champing of the mouth, with frothing of the saliva; and when the tongue is bitten the froth is bloody. Violent and irregular movements of the lips and tongue take place, but with care you can prevent the tongue from being nipped by the teeth and bitten. After the clonic convulsions the patient lies exhausted and helpless, often passing into a deep sleep and sometimes into coma. He complains of intense fatigue, and, if aroused, of severe headache. The clonic movements of epilepsy are not purposive; nor are they rhythmical. Hysterical movements are more or less purposive and tend to be rhythmical. After an epileptic attack, the movements may be purposive; the patient will sigh, look round and move or turn over; he may be bewildered and suspicious.

Attacks vary very much in length. Some of them, the *petit mal* attacks, may last only a few seconds. There is every variety between the *petit mal* attacks and the more severe ones. You may have an attack with momentary unconsciousness, slight rigidity and then a small clonic spasm, when the symptoms may cease, and unless a skilled observer is watching the attack its character is apt to be overlooked. But the typical severe attack is one which attracts attention anywhere.

Nocturnal attacks.—Attacks of *petit mal*, it is said, only occur in the daytime, but that simply amounts to the fact that it is difficult to detect them in the night. They probably also occur in the night, but cannot be detected. So that for all practical purposes it is in the daytime that the attacks of *petit mal* occur. Nocturnal attacks of even *epilepsy major* are very apt to be overlooked. About one-third of all epileptic attacks occur during the night, and in a few patients all the fits are nocturnal.

As to the indications which will justify you in diagnosing a nocturnal attack of epilepsy. Supposing you find an adult who is not in the habit of wetting his bed, every now and then at intervals does so, one cause that would occur to you, would be an attack of epilepsy. Or, supposing a patient wake up in the morning, and find his tongue severely bitten, or if there is blood on the pillow, you again have indications suggestive of epilepsy. Another condition which must be borne in mind is that in severe attacks where the rigidity of the tonic spasm lasts a comparatively long time, there is a tendency for petechiæ to occur, and it is not unusual to find them scattered about the chest and limbs. Supposing you find a patient with petechiæ of unknown origin, one possible cause is a nocturnal attack of epilepsy. This is important, because the appearance of petechiæ has before now led to the supposition that an attack of small-pox was coming on, whereas they have been due to an attack of epilepsy. There is a tendency after an epileptic attack for a patient to turn upon his face; and as he may remain more or less comatose for some time, he may readily be suffocated. When a man therefore is found dead in bed, and lying on his face, he probably has had an attack of epilepsy.

Attacks of petit mal.—These are by the patient and his friends very often spoken of as attacks of fainting. The patient is said to have frequent attacks of fainting. But if you see a case you will probably find that the patient when talking or busy will suddenly stop in whatever he is doing and his pupils will become widely dilated. For instance, Dr. Chambers refers to a lecturer subject to such attacks, who during his lecture, would suddenly stop in the middle of a sentence and remain with the mouth open and rigid for ten seconds, and then go on again as if nothing had happened. The attacks may consist of momentary unconsciousness, accompanied with rigidity for a few seconds, and a vacant look. As a rule, if the patient has anything in his hands he will drop it, but he need not fall to the ground. So slight are the attacks that unless the individual is carefully watched, they are invariably overlooked. For instance, in one case which Dr. Fagge refers to, a girl liable to these

attacks used, when sitting in a chair, to fall out of it, and before anyone had time to reach her she was up again and at work, quite unconscious that anything had happened. In a case that I saw time some ago, a man, an out-patient, was describing his symptoms, when he suddenly stopped talking, his face paled, his pupils became widely dilated, and he proceeded to spit around the room on everybody. He had had a momentary attack of *petit mal* which was hardly noticeable, but which passed into a post-epileptic stage that was always getting him into trouble, and for which he came for advice. Dr. Fagge records another case of a patient to whose heart he was listening, when it suddenly ceased to beat; he found the man pulseless and thought he was dying, but in a few seconds the man got up, his heart was beating again and his whole condition was perfectly normal. Dr. Fagge found that the man was subject to these attacks, which were undoubtedly *petit mal*. These attacks, of which patients often make light, are extremely important, because when mental degeneration developes in the course of epilepsy it largely depends on the frequency of the attacks, whether severe or slight, and in no variety do you get more rapid mental degeneration than in that in which several attacks of *petit mal* occur daily. A patient who has a severe attack of epilepsy once a week or so, can live for years without loss of mental power; while less severe but more frequent attacks are almost certain to result, at an early date, in mental degeneration. They are very important for this reason, and also because the treatment which successfully checks severe attacks, is not as a rule, successful for the slight attacks.

In these cases, sometimes, there is an aura, such as an attack of vertigo, but often the patient has no warning, and, more often than not, is quite unconscious that he has had an attack; he may be, in fact, perfectly unconscious that anything unusual has happened.

To pass on to the *post-epileptic stage*, with which it is important you should be familiar. The usual history, after a severe attack of epilepsy, is that the patient lies helpless and exhausted, but may turn round and look about; he remains drowsy, and, if left alone, falls into a stupor which may last for even twenty-four hours. It is most undesirable to disturb him during that condition. The friends often try to rouse the patient; if this is done he will be very irritable, and in most cases suffer from intense headache, which he would probably have escaped if he had been left alone and allowed to sleep. It is most undesirable to irritate him; it is far better to allow him to sleep off the attack. Occasionally a few slight clonic spasms occur, but as a rule they are not severe. In some cases, however, there is more than drowsiness; there may be profound coma, and if a patient is brought up to the hospital without any history, after having had an attack, you may simply be able to make out the presence of coma, and will have considerable difficulty in making up your mind as to the cause. If you can learn that there has been a fit, you have to distinguish between an epileptic and an ordinary apoplectic attack. In the one case the patient will be perfectly well next morning, and in the other he may wake up paralysed. You have, first of all, to examine the patient to see if there is any evidence of hemiplegic weakness, and if there is such evidence, the attack was probably not one of epilepsy. An apoplectic attack from cerebral hæmorrhage very rarely begins suddenly. When you see in the papers that a person has suddenly dropped down dead in the street, make up your mind that he has not died of apoplexy. The probability is that it was due to cardiac failure. Epileptic attacks begin suddenly, so that sudden onset would be in favour of the coma being a post-epileptic condition, rather than a sequel of cerebral hæmorrhage.

The physical signs to be noted in a patient immediately after an epileptic attack are of importance. The knee-jerks are lost immediately an attack is over, but after a short time, as the spinal cord recovers itself and the shock passes off, the knee-jerk returns and becomes exaggerated, ankle-clonus appears and is most marked on the side to which the head was directed at the onset of the attack.

The patient is generally in a state of deep sleep, and there is a tendency for him to turn over on to the face. It is therefore always desirable that someone should watch the patient for at least half an hour after an attack.

It has recently been shown that the plantar reflex is much more complex than was previously supposed; the typical plantar reflex, when you tickle the sole of the foot, consists of plantar flexion of the toes; if the stimulus is continued and the reflex is vigorous, the knee is also flexed, the foot is drawn up and the thigh is adducted. I want to draw your attention particularly to the movements at the metatarso-phalangeal joints. In a healthy adult, the toes flex; but if there is any lesion, however slight, of the lateral columns, or any condition

of spasm, instead of the toes flexing, the tendency is for the toes, especially the great toe, to be over-extended. This is a very important physical sign, and may be called an extensor plantar reflex. The condition of the plantar reflex after an epileptic attack is extensor form; this is due to the discharges that have taken place and have exhausted the lateral columns; it is ultimately replaced again, by the flexor reflex. The early reflex remember is the extensor reflex. If in a person lying comatose you find an extensor reflex, this would favour the view that something had interfered with the nutrition of the lateral columns, and would be in favour of the condition being the sequel of an epileptic attack.

Condition of *Automatism* often occurs after an attack of epilepsy, more particularly after the minor attacks. These conditions are extremely remarkable and very often lead to great trouble. After an epileptic attack, which has probably been an attack of *petit mal*, and may have been overlooked by the friends, you occasionally find patients going through most complex acts; the condition of automatism, as a rule, lasts for only an hour or two, but exceptionally for more than a day. For instance, Charcot had a patient, who on one occasion, after an attack of epilepsy, got into a train, and while it was travelling climbed on to the top of the carriage, and there was the greatest difficulty in rescuing him. He was taken by the gendarmes locked up in prison, and brought before the magistrates. He then absolutely denied that he had been in a train. On another occasion this man, who lived in Paris, had an attack, and when he came to, he found himself in Marseilles. In this post-epileptic condition he must have taken a ticket to Marseilles, and have been able to talk and mix with people without anyone discovering anything very remarkable, yet when he recovered his normal condition, he was quite unaware that he had travelled to Marseilles.

It is during this automatic stage, that murder may be committed unconscious by one. An epileptic patient after an attack may be seized with a violent hatred. For instance, I saw a small boy who used to have epileptic attacks; after one, he would break up his toys and destroy everything he could come across; when he came to, he would thrash his small brother for having broken his toys. It is very important, therefore, to recognise this condition, as in some instances, a man in this post-epileptic stage has murdered his wife or children, and when he has recovered he has had no recollection of anything that had occurred. The man, to whom I was referring just now, who had an epileptic attack in the out-patient room, complained that when he was out, he was constantly being knocked down by people and thrashed, and he could not understand why. The reason was not obvious to us, until we actually saw him immediately after an epileptic attack, when he began to spit at everybody, and then we saw the solution of his problem. It was a remarkable case. He was a civil, decent-speaking man, but during the post-epileptic stage, which lasted only four minutes, his language was most vile and foul and he was spitting at everybody. As soon as the attack ceased, he could not understand why there was such a large space left between him and every one who was looking on. These irresponsible actions, vary very much, and the public entirely fail to recognise their causation, so it is the more important that medical men should not overlook their significance. For instance, I had a patient, a woman, who used often after an attack, to strip and go out into the street, much to the annoyance of her husband; she had been found on several occasions stark naked, running about in the street. In other cases people will be very destructive, or may perform all sorts of complex acts, some of them very complex. For example, one of the poets of the last century wrote some of his best verses in the post-epileptic state. There was a man, up at Cambridge in my time, who used to write essays, often very brilliant ones, which he would find in his room, when he woke up in the morning, in his own handwriting, on all sorts of subjects. He had no recollection of writing them, and not unfrequently the subject even had not been in his thoughts. He was subject to slight attacks of epilepsy and doubtless the explanation was, that after a slight attack he had written for an hour or more, quite unconsciously.

HYSTERICAL ATTACKS. There is no doubt that, in England, at any rate, women are much more excitable than men, and the majority of the attacks of hysteria occur in women. In England it is not at all common to meet with hysteria in men; in France it is apparently extremely common.

A hysterical patient will never perform, so to speak, without an audience. If a patient has a fit in a room when she is by herself, this is very strong evidence against its being hysterical. The patient is usually attacked under circumstances where he or she can get a certain amount of sympathy. There is no loss of consciousness. There is not that initial cry which you hear in epilepsy; the patient screams and shouts during the attack, but does not emit the

single initial cry. An epileptic patient has widely dilated pupils, with an insensitive conjunctiva. On the other hand, if you touch a hysterical patient's conjunctiva it is sensitive, and although the pupil may dilate with excitement, still it is not widely dilated. A hysterical patient never hurts herself; however violent she may be, she never does any serious damage to herself. But she very frequently hurts bystanders. In an epileptic attack the patient frequently hurts himself, falling down, cutting his head, or into the fire; or damaging himself in some way, but there is nothing purposive in his movements; he never clutches at or knocks bystanders. You can rouse an hysterical patient. If you apply a sponge with a strong Faradic current to the skin, you can, as a rule, control the patient's movements and stop the attack. In epilepsy it would not be so. In hysteria the movements are very much more purposive and hythmical than in epilepsy. A hysterical patient may repeat one movement over and over again, and yet she may also be tossing about in bed, moving herself here, there, and everywhere. You never see a post-hysteroid automatic condition. These automatic movements follow true minor epileptic, but not hysterical attacks. In hysteria there is no initial tonic stage. If you see a patient at the onset, you will notice clonic movements from the first. In an epileptic attack there is always a tonic stage, but in Jacksonian epilepsy there may be only a local clonic spasm. Hysterical patients do not froth at the mouth, nor does deviation of the head and eyes to one side occur; moreover, the patient generally has to be held down, on account of her violence.

Hysterical attacks may last for a quarter of an hour, and sometimes the patients are extremely violent. I remember a great many years ago, down in the country, the case of a man who was said to have acute mania, and the whole village was in a state of excitement about him. I found him in violent convulsions, but hurling anything within reach at his mother-in-law, breaking things, hurting his wife if she came near, and creating a great disturbance. The question was, What was the cause of his violence? Was it an attack of acute mania or not? Or was it the result of local brain disease? It obviously was not due to epilepsy, because the attack had lasted for an hour or more, and I carefully made certain of the absence of evidence of organic disease. On watching the way he attacked bystanders, it was clear that the case was one of hysteria. I procured a Faradic battery and applied a strong current under considerable difficulties, because I had his wife and her mother protesting, on the one hand, and not willing to assist; and the man struggling, on the other, while the villagers were too frightened to help. But I tied on two sponges tightly, and applying the current, allowed him to struggle to his heart's content. At the end of a few minutes he became quite sensible, and his violence ceased; nor did his attacks return, as he realized it would entail a recurrence of the treatment.

Such patients require vigorous stimulation, but care must first be taken to exclude organic disease of the brain.

Generally in the treatment of these hysterical attacks, there is nothing better than stimulation by a Faradic current. In private practice, as friends often object to its use, an injection of apomorphia may be given. There is no risk if you give a moderate dose; it certainly very quickly brings an attack to a stop. There is great difficulty in dealing with attacks which last for half an hour or more, and occur frequently; if you sympathise with the patient and if vigorous treatment is not adopted, the trouble is very great, because the attacks recur so constantly. The best treatment is to Faradize the patient vigorously the first time, and tell her that if another attack occurs, you will employ the same method to effect a cure. It is no use to employ half measures. But, first, be careful, before you make up your mind that the attack is one of hysteria.

I was once asked to see a boy with hysterical convulsions, who had been repeatedly severely Faradised without putting a stop to them. I had the opportunity of watching an attack, which commenced as a local chronic spasm in his fingers, which then spread up his arm. Further examination showed that he had a cerebral abscess, from which he died a few days later. The treatment, of course, was absolutely wrong, and did harm instead of good. You must be very careful to note whether you may be dealing with localized convulsions, such as would be produced by a cerebral tumour.

I have put down *hysteria minor and major*. The attacks of shouting and crying with or without clonic convulsions which we usually meet with, may be called hysteria minor. But, from time to time, you meet with patients who have the most violent convulsive movements, violent opisthotonos, lying with only the head and feet touching the bed, also with violent movements of the arms. The patient throws herself into all sorts of positions, so that it is quite impossible to keep her lying in bed at all. These movements may continue for hours; the

attacks are not common, but they do not differ except in degree from the minor attacks.

Hystero-epilepsy is a word which is often used, but it is unsatisfactory because it is not used by everyone in the same sense. Hystero-epilepsy is applied more often than not to these major attacks of hysteria, but it is much better to call them hysteria major than hystero-epilepsy.

Besides the above, we meet with cases which are often puzzling, in which a patient has an epileptic attack which may only be a slight attack of *petit mal*, but in which there is momentary unconsciousness, or there may be slight tonic or convulsive movement; this is quickly succeeded by an attack of hysteria, which alone may be noticed by most observers. Such conditions are difficult to treat, because the firm moral treatment which is sufficient to prevent ordinary hysterical attacks is quite useless in preventing attacks in which the initial stage is due to epilepsy. Fortunately these are not common, but when a patient has repeated hysterical convulsive attacks, they, when carefully observed, may be shown to be almost invariably preceded by *petit mal*. In such cases you must treat the epilepsy, and also, when the hysterical condition comes on afterwards, be firm with the patient, and not allow the attack to run on.

In speaking of JACKSONIAN EPILEPSY we refer to a group of convulsive attacks which arise in connection with gross cerebral lesions, lesions due to irritation, but not destruction of the motor cortex, and varying according to the particular area which is affected. These generally commence with local clonic convulsions. Supposing that the area in the right motor cortex representing the hand is affected, the fit may commence with twitching of the thumb, followed by clonic movements of the wrist. Sometimes the discharges extend over a much wider area, and the whole arm is affected, then the face, when the head will be turned to the right side with deviation of the head and eye to the right. Clonic movements of the leg follow, and, as a rule, as soon as one half of the body is involved, consciousness is lost, the movements spread to the opposite side, and general convulsions ensue. They differ from true epilepsy in these essential characteristics. In Jacksonian epilepsy there is no initial tonic stage, and the clonic movements start in a definite group of muscles, and at first there is no loss of consciousness. But when an attack has become general, it cannot be differentiated from a true epileptic attack unless you see it throughout. There is always very much more paralysis following these attacks than in true epilepsy. In Jacksonian epilepsy the muscles that have been much involved, more particularly those in which the clonic movements commence, are paralysed for a longer or shorter time, according to the severity of the attack.

The treatment of epilepsy.—Many of the attacks are preceded by a definite aura. If the aura commences in a distal area, such as the hand, you will find that the immediate application of a ligature encircling the arm may prevent the onset of an attack: and this is also true in cases of Jacksonian epilepsy. I had a patient who, so long as he had a piece of wood in his pocket, which he could grasp; was able, the moment he felt the aura, by violent contraction of his fingers on the wood, to stop the fit. But if the piece of wood were taken away, the next aura that came on usually terminated in convulsions.

Smelling-salts are sometimes used as a remedy. When the aura is sensory, nitrite of amyl or nitro-glycerin may be efficient. Still it is comparatively rare that you are successful with this line of treatment; in many instances the interval is so short, and the capacity to apply the remedy in time is so very rare, that there is not a very great field for it.

As to general treatment, there is no question that patients should avoid alcohol. In some cases, in which the epilepsy has become chronic and the attacks are frequent, the patients seem to thrive better on vegetable than on meat diet. At any rate, anything like heavy meals should be avoided, and, without laying any great stress upon it, there is a good deal to be said for patients who suffer from repeated attacks cutting themselves down to a farinaceous and vegetable diet, and taking very little meat.

For severe attacks of epilepsy there is no drug to compare with bromides, and the experience at the National Hospital, where they use bromide by the ton, is that there is no great objection to bromide of potassium. Certain authorities have laid down that bromide of potassium is a depressing salt, and consequently it would be very injurious when given in large quantities. The experience there, where they have given this drug to a very large number of patients, is that there is no evidence at all that the patients have done any worse with bromide of potassium than with bromide of sodium or ammonium. All three salts are efficient, and some think that ten grains of each is better than thirty grains of one of them. I do not think there is any clear proof in favour of one more than another. You have to bear in mind

that every fit a patient has, predisposes to another, and that therefore, as time goes on, the greater is the difficulty in curing them. Hence the importance of putting the patient under bromide regularly when fits first occur, instead of waiting for a year or so until they become severe.

As a rule, patients commence with fits at intervals of a few weeks or even months. It may be difficult to administer bromides for a few weeks, if there has only been one fit. But in the case of a patient who has had a second fit, I should advise a prolonged course of treatment. It does not seem to matter very much whether you give small doses several times in the day, or a fairly large dose twice a day. When the fits are at all frequent it is no use to give less than a drachm of bromide at night, or twenty grains three times a day. I always give half a drachm three times a day when the attacks are frequent; this ought to be continued for months after the last fit. It is wise for such patients to take at least a drachm a day for a year, and if during that year he has no fits at all, then he should take a single dose of twenty grains at night for another year. If you keep patients under treatment for two years in that way, as a rule you entirely cure them, but if you allow patients to have a series of fits running on for four or five years, then the difficulty is very much greater than if you deal with them at the onset.

In some cases it is not sufficient to give bromides alone, as the fits will recur. You will find that where there is low arterial pressure, sometimes the addition of digitalis or strophanthus is very efficacious. Arsenic is a useful drug; belladonna and many others are recommended from time to time; but those I have named are the more important. Latterly bromide of strontium has been recommended, but it has not proved to be any better than the other bromide salts.

Treatment of petit mal.—Attacks often persist in spite of treatment with bromides, and the drug which seems to do the patients more good than anything else, is ten grains of borax three times a day. Still the attacks are very difficult to stop, and sometimes they will go on in spite of every form of treatment. A combination of thirty grains of bromide and ten grains of borax sometimes produces good results.

In the case of a certain number of patients it is difficult to predict the effects of these drugs upon them. When taking the drugs some will pass into a state of intense distress and misery so long as the fits are absent, and they will feel perfectly well and comfortable while they are having fits. Sometimes, when the fits cease, the patients refuse their food and pass into a condition of melancholia. Such conditions are difficult to treat; if you persist with your medicine they generally have to go to an asylum for melancholia, and in the asylum the administration of the bromide is generally stopped, and the patients return to their epilepsy. I am afraid that, with our present knowledge, we have no means of curing these cases. But you cannot tell at all which are the patients in which that condition will occur, and sometimes it occurs very early in the disease, so that there is a certain group of cases which, in spite of everything you do, will become weak-minded and drift into an asylum. There is no doubt that in an asylum a large number of the epileptics have gone there on account of this condition. They are either melancholic or have fits.

Status epilepticus is a condition in which one convulsion succeeds another. This occurs in *general paralysis of the insane* in *tabes*, *insular sclerosis*, and in *alcoholism*, with some *gross cerebral lesions*, but rarely in true epilepsy. Bromide is absolutely useless in a status epilepticus. The best drug is chloral which should be given in fairly large doses. You may have to give even as much as a drachm and a half, but, as a rule, a drachm of chloral given per rectum will stop an attack, and that treatment may be repeated after a few hours. Chloroform is often necessary if the attacks persist, because you must bear in mind that a status epilepticus tends to induce hyperpyrexia, and the rise of temperature should be stopped at all costs, otherwise the patient will die of hyperpyrexia. Morphia also is useful in some cases.

As to Jacksonian epilepsy there is no doubt that bromides control the attacks, but when you can deal successfully with the condition surgically, that is the better line of treatment. Remember when you treat Jacksonian epilepsy surgically, you may replace the epileptic convulsions by paralysis, and some would rather have a fit of epilepsy once a week than be permanently paralysed.

Royal Army Medical Corps.

The Medical Council are authorised to nominate a candidate to fill one of the vacancies in the above corps, and will be pleased to consider applications from qualified Students of Guy's Hospital.

Applications should be addressed to the Dean, Medical School, Guy's Hospital, on or before Thursday, March 1st.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

CASES UNDER DR. TAYLOR.

MARY 46. Locomotor ataxy. Charcot's knees.
48. Mitral regurgitation.
49. Anæmia. ? Addison's disease.
Cot 56. ? Diphtheria. Tracheotomy.
PHILIP 22. Mitral stenosis. Tricuspid regurgitation.
23. Pleurisy.
25. Chronic tubal nephritis.
27. Myelitis.
30. Myelitis after injury.
33. Tumour in loin. Operation. Fæcal fistula.
35. Hæmoptysis. Enlarged liver.
37. Hodgkin's disease.
40. Infective endocarditis.

CASES UNDER DR. PITT.

MARY 25. Chorea.
26. Acute pneumonic phthisis.
27. Influenza.
28. Profound anæmia. Œdema. Right pleuritic effusion.
29. Hæmatemesis. Gastric ulcer.
30. Chronic bronchitis.
31. Chorea.
32. Gastric ulcer.
33. Subacute rheumatism.
34. Chlorosis.
35. Rheumatism.
36. Typhoid.
37. Gastric ulcer.
Cot 55. Marasmus.
STEPHEN 21. Spastic paraplegia.
22. Diabetes mellitus.
23. Stricture of œsophagus.
24. Appendicitis. Operation.
25. Aortic incompetence. Syphilis. Influenza.
26. ? Hydronephrosis.
27. Carcinoma of stomach. Gastrectomy.
28. Right pleuritic effusion Drainage.
29. Posterior left basic pneumonia.
30. ? Insular sclerosis.
31. Chronic dermatitis. Syphilis.
32. Chorea. Apical systolic bruit.
33. Typhoid.
34. Mitral stenosis and incompetence.
35. Chronic nephritis.
37. Mitral stenosis and regurgitation. Tricuspid regurgitation. Thrombosis femoral vein.
STEPHEN 38. Acute nephritis.
39. Hæmaturia.
40. Phthisis.
Cot. Right basal broncho-pneumonia

CASES UNDER DR. PERRY.

MARY 1. Diabetes mellitus.
2. ? Uræmia.
3. Abscess in right hypochondrium. ? Suppurating gall-bladder.
6. Chorea.
7. Pernicious anæmia.
9. Movable kidney. Thrombosis of femoral veins.
12. Ataxic paraplegia.
Cot 51. Meningitis.
STEPHEN 1. Syphilide. Squamous.
3. Dilated heart, with pleuritic effusion and enlarged liver.
5. Appendical abscess. Operation.
6. Dilated irregular heart. Pleuritic effusion. Bronchitis. ? Tricuspid regurgitation. ? Granular kidney.
7. Appendicitis. Stenosis of smaller intestine from adhesions. Operation.
9. Dilated stomach.
11. Empyema. Displaced heart.
14. Emphysema. ? Phthisis.
15. Mitral stenosis and regurgitation. Aortic regurgitation ? Pleurisy.
16. Tubercular laryngitis. Phthisis.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

ASTLEY-COOPER 12. Injury to perineum.
26. Fractured patella. Wired.
27. Fractured ribs. Bronchitis.
JOB 2. Necrosis of tarsus. Sime's operation.
6. Epithelioma recti.
7. Abscess in axilla. ? Tubercular shoulder joint.
22. ? Tubercular knee.
25. Foreign body in knee. Removed.
LYDIA 6. Epithelioma of cheek. Operation.
7. Amputation through thigh. ? Tubercular knee and ankle.
11. Tubercular hip. Operation.
12. Necrosis of jaw.

CASES UNDER MR. LUCAS.

ASTLEY-COOPER 11. Fractured pelvis. Ruptured urethra.
15. Separation of epiphysis of head of femur.
21. Separation of lower epiphysis of femur.
25. Fractured patella. Wired.
LAZARUS 4. Loose external semilunar cartilage.
6. Hip disease.
10. Epithelioma of penis. Amputation.

MARTHA	5.	Swelling in neck. Lymphadenoma.
	9.	Tubercular elbow and knee-joint.
	21.	Strangulated hernia. Resection of intestine.

CASES UNDER MR. GOLDING-BIRD.

CORNELIUS	1.	Fractured patella.
	5.	Burn. Excision of eye.
	14.	Partial dislocation of knee.
	17.	Crushed leg. Amputation.
	18.	Gangrene of leg. Stokes-Gritti amputation.
LUKE	5.	Appendicitis. Operation.
	6.	Sacro-iliac disease.
	9.	Growth of kidney.
	10.	Enlarged prostate.
	13.	Carcinoma of rectum.
CHARITY	6.	Sarcoma of scapula.
	13.	Tubercular hip.
	14.	? Actinomycosis of face.
	16.	Carcinoma mammæ.
	17.	Nephrorraphy.
	20.	Carcinoma mammæ.
	22.	Hæmaturia.

CASES UNDER MR. JACOBSON.

CORNELIUS	2.	Separated lower epiphysis and fractured lower end of radius. Operation.
	6.	Compound comminuted fracture of lower jaw. Wired.
NAAMAN	4.	Congenital hydrocele of cord and varicocele. Operation.
	8.	Gluteal sinus. Tubercular.
	10.	Stricture of urethra.
	14.	Double inguinal hernia. Radical cure.
	18.	Traumatic osteitis of skull.
DORCAS	7.	Sarcoma of ilium.
	9.	Tubercular knee-joint.
	13.	Hip disease.
	14.	Carcinoma recti. Inguinal colotomy.
	18.	Fractured femur and humerus.

CASES UNDER MR. SYMONDS.

JOB	13.	Stricture œsophagus. Gastrostomy.
	15.	Pyloric obstruction.
	18.	Epithelioma of tongue and larynx. Exploration and tracheotomy.
	19.	Epithelioma of larynx. Tracheotomy.
LYDIA	19.	Goître. Isthmus excised.
	21.	Biliary fistula.
SAMARITAN	11.	Septic thumb. Lymphangitis.

CASES UNDER MR. LANE.

LAZARUS	13.	Tuberculous disease of ankle-joint.
MARTHA	10.	Movable kidney.
	13.	Cystic disease of breast.
PATIENCE	5.	Tuberculous dactylitis.
SAMARITAN	8.	Tuberculous abscess in neck.

CASES UNDER MR. DUNN.

LUKE	2.	Stricture of œsophagus.
CHARITY	4.	Sarcoma of humerus.
SAMARITAN	12.	Erysipelas.

CASES UNDER MR. FRIPP.

NAAMAN	20.	Dermoid of eyelid. Removed.
	22.	Tubercular osteitis of femur and abscess drained.
DORCAS	20.	Enlarged thyroid. Removal of right lobe.
PATIENCE	14.	Suppurating glands in neck.

With the Army Medical Corps in South Africa.

(BY OUR SPECIAL CORRESPONDENT.)

Wynberg,
Tuesday, January 16th, 1900.

DEATHS and post-mortems are very rare here; especially now that the Orange River and De Aar hospitals keep the more serious cases until they are fit to travel, and orders are said to have been issued against sending down any more fractured thighs. I have myself only had four fractured thighs. One was already united, having been wounded five weeks previously at Elands Laagte and detained in Natal since. The second was wounded at Belmont, the femur being fractured just below the great trochanter and fissured, at 400 yards range. He was left five hours before being dressed at the field hospital; and arrived here six days later with his wound in a most putrid condition. Finally he died after three weeks' continued suppuration. The third and fourth cases were wounded at Magersfontein, both in the lower third of the femur, and were kept at Orange River till the 21st ult. One went seventeen hours before receiving any treatment, and thirty-two before he was carefully dressed. He is suppurating freely still with two bare ends of bone opposing each other; and after many incisions and counter-incisions he is at last doing well, his temperature having just returned to normal. His colleague, however, Sergeant V., was wounded in the lower third, as before, but the bullet lodged; and, although going thirty-nine hours without any treatment at all, the wound was all but healed on his arrival here, twelve days later. He is now convalescent, except that the bullet is still inside him, lying directly above or beneath the lower fragment. It is being localised, and in a day or two we shall probably operate, unless the bullet is in too great proximity to the blood-vessels, or there is other obvious risk.

This makes an instructive series. The one from Natal was carefully treated from the first The two Magersfontein cases passed a day and a half before being properly attended to, and one has in consequence been suppurating freely; but being kept at Orange River for twelve days, and having had the thigh freely incised, the

prognosis is good. The only fatal case is that from Belmont, where, although properly dressed and splinted within five hours, the wound received no further attention for five days, part of this being spent on the journey, and a fatal result ensued. The mortality in cases of fractured thigh, indeed, was chiefly due, it would seem, to want of proper dressing in the first few days; and difficult as it is at any time to dress such serious cases while on board the hospital-train, it was impossible to do so on the first working journey that the train took, when the floors were littered with extra passengers and when the staff were unused to their duties.

There have, however, been two interesting post-mortems in the last ten days. One case was that of a man in the Coldstreams who was hit five weeks ago by a bullet which entered under the left clavicle in front and lodged. The wound closed readily; but there was some dyspnœa and pain in the left side, and a pleuritic effusion developed. After a fortnight there was a definite pneumothorax on the left side, and a little later the temperature rose and assumed a definite septic type. There were no signs of external suppuration and it was presumed that the contents of the left chest had become septic. There could be no question now as to the necessity of opening the chest, but before the pyrexia developed there had been a consultation between several of my colleagues as to the advisability of opening or aspirating, and while some said the pulse was small and feeble, another came back the next minute from the bedside and said it was quite normal again. The explanation of this did not occur until the next day when it was found that the pulses were markedly unequal and the left pulse had almost vanished. This pointed to an aneurysm, of which, however, there were no other definite signs; and while the effusion was still aseptic, it was urged by those who supported the aneurysm theory that it might be dangerous to drain the chest. However, the septic temperature developed and a rib was accordingly resected. The breathing, however, did not improve and the patient remained in a weak state until towards the end of the fifth week from injury, when the patient died rather rapidly, blood appearing in the discharge from the pyopneumothorax. In the mortuary, the left lung was found collapsed, heart, pericardium and aorta were unaffected, but there was a quantity of blood in the left chest, and a tough mass was found closely adherent to the chest wall in its upper part, which, on dissection, proved to be an aneurysm of the first part of the left subclavian, which had opened by a small opening into the cavity of the pneumothorax. The bullet had traversed the body of the second dorsal vertebra but could nowhere be found.

The second case had had a long history of four or five weeks. He was shot by a bullet entering above the crest of the ilium on the right side, passing through the soft tissues upwards and inwardly through the spine and left chest, and out at the inferior angle of the left scapula. There were no abdominal and for long no chest signs of importance; but from the first the man had complete paralysis and loss of sensation from the third lumbar vertebra downwards. Curiously enough, sensation began to return in a fortnight and was completely restored before death; and power returned simply to the left sartorius and to no other muscles. An injury through the motor and not the sensory half of the cord was seriously suggested by a consulting surgeon. Pyrexia set in; and one day, unexpectedly, an abscess pointed and was opened close to the exit wound. The chest had been carefully examined at regular intervals without any signs of empyema presenting themselves. On the incision being made, frothy pus was discharged, and the surgeon in charge accordingly diagnosed a pulmonary abscess. The pyrexia became extreme and the patient sank and died. In the mortuary a fœtid collection of pus was found on either side of the lumbar and spinal cord, communicating with the spinal column. The left lung showed, as diagnosed, a pulmonary abscess, but was otherwise clear. The cord in the region of the cauda equina was flattened out by a semi-organised mass of septic blood-clot, but the cord and cauda themselves exhibited only a slight recent superficial scar on the dorsal aspect. The results were undoubtedly those of compression, and it is possible that laminectomy, which would have been obviously justifiable, might have saved the case.

An interesting and exciting case of a small, either internal or external, carotid aneurysm behind the jaw was made out in the theatre the other day, during an operation for removal of a few loose pieces of bone from a fractured jaw. Violent hæmorrhage from somewhere suddenly occurred, blood pouring out through the nose and refusing to be controlled, except by compression of the carotid. The carotid was accordingly ligatured; and great credit is due to the civil-surgeon who did it, as there were a multitude of senior officers present who advised and assisted in various ways, and in the hurry of the moment passed an aneurysm-needle by mistake through the vein. The patient, however, has done well.

A trainful of sick and wounded came down on Sunday, January 14th, from De Aar, just the sweepings of the Orange River and De Aar hospitals, which have of course to be ready for any emergency. These will mostly go straight home next week. My own cases include half a dozen of synovitis of the knee, mostly from a loose cartilage, a dozen of subacute rheumatism, and half a dozen of acute catarrhal dysentery, as Osler calls them, on the way to recovery; together with two of hernia, one of enterica (who was not inoculated), a tubercular pleurisy, an epileptic and a man with malarial cachexia, a flesh-wound of the calf, another of the arm, and injury to the musculo-spiral nerve, gradually clearing up, and a fractured jaw with subluxation and a lodged bullet.

Of Guy's folk it may be added that Nursing-Sister Tippetts, No. 5 General Hospital, has arrived, and is attached temporarily to No. 2 here; Lieut.-Col. Hodson, hitherto in charge of A division of this hospital, is to be secretary to the P.M.O. lines of communication, Col. Stevenson; and, finally, Civil Surgeon Hancock has grown a beard.

Tuesday, January 23rd, 1900.

Who is the ugly scoundrel who has not sent me my GAZETTES? Friends write me delightful letters, but for hospital scandal always refer me to the GAZETTE; and the last number I had was for October 7th, 1899. Will someone kindly lend me the money for my subscription for the year, and pay it in to the Librarian? Perhaps by appealing to the generosity of the Guy's public instead of the editor only, I may thus be allowed to have the privileges of the Clubs' Union. Otherwise I write the weekly letter in fear and trembling, lest I should repeat myself; and give different versions of the same tale. Perhaps a statement, so far as we can know it unofficially, of the disposition of the hospitals may be of some interest; although it will be considerably behind date by the time it is published. *Field hospitals*, one to a brigade, like the bearer companies, two to a brigade, and the officers attached, one to each regiment, of course move about with the units to which they are attached, and are emptied into the *stationary* and *general hospitals* as soon as may be, in order that they may be ready for the next engagement. Amongst these one may mention the Australian Hospital, which was near Zoutpans Drift, near Orange River, when it sent me down a few patients the other day.

Of the four *stationary hospitals*, one is in Natal, I believe at Pietermaritzburg; another at Orange River, and a third at De Aar. That at Orange River must be very full: as one of the Australian doctors, who has been invalided down with dysentery, says that on his way through Orange River there were 400 patients, many of them, of course, dysenterics and typhoids, with at that particular moment only one officer available to manage the whole lot; although he has since been reinforced.

As to the *general hospitals*, *No. 4* arrived recently and has been sent on to Natal, to be established, it is believed, near Estcourt, perhaps at Chieveley which stands high. *No. 1* being established here in wood and tin is sure to stay here to the very last. *No. 5* only arrived last week, and is expected to go to Colesberg. *No. 3*, to which the Portland Hospital is attached, is at present very pleasantly situated at Rondebosch, not far from Mr. Rhode's house, and is doing good work; while *No. 2* is our next door neighbour in the Camp here at Wynberg, and like No. 3 is under canvas with boarded floors and other delights. Probably before another month is out, No. 3 will have moved up towards, perhaps actually to, Kimberley; and it is not unlikely that by the end of February No. 2 may find itself at Bloemfontein. It would be extremely difficult to transport a general hospital, 500 iron beds, tents, and all, by waggon; and so it may be presumed that they will be moved along the line of the railway, hand over hand as it were, until the lucky one at length arrives in Pretoria. Of course, what one would like would be to be stationed at Johannesburg during the expected seige of the capital, only twenty-eight miles away. This method of advancing the hospitals will begin by the establishment of No. 5 up country, while 1, 2, and 3 remain for the present in the Cape peninsula.

As to the hospital-ships, the Maine arrived in Table Bay yesterday and to-morrow sails for Durban with, amongst others, Sir William Stokes, Mr. Kendal Franks (recently senior surgeon at the Adelaide hospital, Dublin; and since then for three years at Johannesburg), and Mr. Watson Cheyne and Mr. Cheatle of King's College hospital. A civilian surgeon also, Mr. Porteus, who has been attached here for a few days, has been ordered to proceed to Durban in the Maine. What the Maine will do when it arrives at Durban and has discharged its passengers, only the authorities can know. With No. 4 general hospital now in Natal there can be no need for patients to be brought here for treatment, as the Trojan and the Spartan have hitherto been doing. Durban harbour is hardly fitted for a hospital ship to stay in simply as a hospital; and with these splendid transports like the Majestic going home in fourteen days, it would be strange if the hospital-ships were to be used for shipping patients home in twenty-four or more. Perhaps they will be employed for bringing patients to Table Bay, to be transhipped into home-going transports. At the same time one must realize that the sea voyage is in itself a very good form of treatment for most of the wounded and for many of the sick; and the extra length of voyage made by these ships may be an advantage in itself. The Princess of Wales is at present lying out in Table Bay awaiting orders, but as she took twenty-eight days over her voyage out, and has seen better days, she is less likely to be employed for long voyages.

As to the trains: No. 1 is in Natal. Nos. 2 and 3, of which everyone at home must have seen innumerable photographs, are engaged in running up and down the country. No. 4, with Sister Stephen, I suppose, on board, will soon be at work in the same way; and "Cape-Town No. 1"—a grey train made of converted horse boxes, with brackets for stretchers instead of bunks, is doing laborious work between Cape Town, Wynberg, and Simon's Bay. A colleague, Mr. Jameson, of St. Bartholomew's and lately plague-officer in India, took me over to see the "Princess of Wales" last Wednesday the 17th inst. She is, of course, most beautifully fitted up, with four wards on the main deck and on the troop deck underneath. These contain cots for 180 men and special swinging cots for four officers; an "aseptic operating room" containing a skiagraphic apparatus (without localising arrangement, and therefore without much chance of being used, if indeed it were wanted, as is hardly conceivable) and in fact, everything on a most sumptuous scale. But when a private yacht has worked privately for some time, and then travelled under the auspices of a tourist-agency for a long time to Norway and the Mediterranean, one cannot expect in the third stage of its existence that it will be as perfect as it may originally have been. In fact, the breakdown at Gravesend, just after starting, and the 28 days' voyage out corroborate this view.

This letter is written under difficulties, on a very small table, at a very late hour of the night, in the barren comfortless wooden quarters assigned to the civil-surgeons of No. 1. Black beetles of a brown colour swarm; and the penalty for trespassing on this paper is death, whereof the floor bears frequent traces. Worse foes abound in some of the quarters, but they have not taken up any position within these four walls.

Some of us were playing tennis on the red mud courts of the Wynberg club this afternoon. No. 1 General Hospital, represented by Drs. Thornton (the Middlesex cricketer) and Fremantle, beat No. 2 (W. I. Hancock and Mr. Hanwell of St. Thomas's) 6–4, 8–6. Guy's then challenged the M.A.B., and beat them easily 6–2. J. M. Gardiner is attached to No. 3 at Rondebosch; and Nursing-Sister Tippetts to No. 2 here. In No. 1 our nursing staff has been reinforced by some sisters from St. Bartholomew's, the London, and Dublin. It is an immense comfort to work with the sisters from London hospitals again; these at any rate are admirable. Our staff of orderlies has also fortunately been increased by a dozen or more St. John's Ambulance men; and our staff of officers by Mr. Gardner, surgical registrar to Leeds Infirmary, and Mr. Hunt who was through the Chitral Campaign as a layman.

[We cannot understand why our Correspondent does not receive his GAZETTES. They are forwarded regularly enough to him from the publishing office.—ED., G.H.G.]

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

A Hospital Corps.

MY DEAR MR. EDITOR,—In view of the fact that the Government has grasped the fact of the utility of men trained on modified Boer lines (*vide* Mr. Chamberlain's reply to Sir William Harcourt of 5th February, 1900), may I suggest the formation of a Guy's Corps on the following lines, in response to the appeal in "Passim":—

1. All Guy's men, past and present, to be eligible, without any regard to age, weight, height, or chest measurement. Freedom from organic disease, however, to be essential, as also the ability to see a regulation bull's-eye at 1,000 yards, with spectacles if necessary.

2. If possible, the corps is to work *in harmony* with the Clubs' Union, and there should be (also if possible) no entrance fee or annual subscription.

3. That application be made to the Government to supply rifles, in return for which each man gives his services for home defence; if a capitation grant can be obtained so much the better, but in lieu, the Government to furnish 150 rounds of ammunition per man and range accommodation free.

4. Each member to undergo a regulation course of musketry under an instructor approved by the Government, and also to perform class-firing according to army musketry (or special) regulations for time being.

5. There is to be no regulation uniform, but each member should, if possible, provide himself with khaki serge Norfolk jacket and wide-awake hat. The jacket need not be made to measure, and could be bought for less than an ordinary Guy's blazer. Knickers and putties would be a useful addition if obtainable at a reasonable price, whilst a bandolier is a necessity.

6. Company and battalion drill and route marches should be encouraged if sufficient uniformity of clothing is obtainable.

With regard to the rifles, I may mention that the Natal Volunteers are at present using the Martini-Enfield or Metford on active service, and the immense stores of Martini-Henry rifles in the various armouries could be suitably converted by Government for a few shillings each. The accuracy of shooting would then in every way equal the service rifle, and to irregular troops, who would be guerilla marksmen rather than ordinary infantry, a magazine is not indispensable.

Any Guy's men who think the idea a feasible one should communicate with me through the Editor of the GAZETTE. My house is quite at their service for the purpose of holding a meeting for the further discussion of the subject.—I am, dear Mr. Editor, yours faithfully,

H. STANLEY TURNER.

Royal College of Surgeons of England.

SYLLABUS of three lectures on "The Anatomy and Pathology of some rarer forms of Hernia," to be delivered in the theatre of the College, on Monday, Wednesday, and Friday, February 19th, 21st, and 23rd, at four o'clock each day, by Berkeley G. A. Moynihan, M.S., F.R.C.S., (Arris and Gale lecturer).

LECTURE I.—Monday, February 19th.—Bilocular Hernia, including Inguino-properitoneal and Cruro-properitoneal Hernia.—Interstitial Hernia.—Definition.—History.—Various positions occupied by accessory sac.—Etiology.—Influence of congenital defects.—Anatomy of the Inguinal region in the fœtus and adult.—Peritoneal pouches.—Symptoms.—Diagnosis.—Treatment.

LECTURE II.—Wednesday, February 21st.—*Reduction in Mass.—Encysted Hernia.*—Reduction in Mass.—Varieties.—Reduction into pro-peritoneal sac.—Reduction of sac and contents.—Rupture of the neck of the sac.—False reduction in Mass. Encysted Hernia,—Definition.—History.—Distinction from Infantile Hernia.—Two forms of encysted Hernia of the Tunica vaginalis.—Encysted Hernia of the cord.—Mode of formation.

LECTURE III.—Friday, February 23rd.—*Hernia of the Bladder.*—Definition.—History.—Varieties.—Intraperitoneal cystocele.—Extraperitoneal cystocele.—Paraperitoneal cystocele.—Mode of formation.—Recognition of Bladder implication.—Symptoms and signs.—Treatment.—Analysis of Cases.—Wound of the Bladder during operation.

EDWARD TRIMMER, Secretary.

Passim.

On another page we give the text of the address which is to be presented to Mr. Davies-Colley. Signatures of past and present Guy's men should be written on slips of paper, or on the backs of post-cards, and sent to us *at once*. We shall try to include as many as possible, but it will easily be seen that the potentialities of the address must soon be exhausted. Hence the necessity for immediate response to our invitation.

It will be remembered that we invited subscriptions from ladies connected with the Hospital towards "comforts" for the sick and wounded in Princess Christian's Hospital Train. Mrs. Pye-Smith now writes that she has received £210 15s. 6d. and eight parcels of clothing, etc. Of the money sent, £50 has been forwarded to Sister Stephen (Miss Creighton) for immediate necessities, while the balance has been given to Princess Christian, who will employ it for "extra comforts" for the wounded. Her Royal Highness desires to thank the subscribers "most sincerely for their more than generous help." We may point out that the necessity for such a subscription as this has in no way failed to exist. Further subscriptions are still in request and should be sent to Mrs. Pye-Smith, 48, Brook Street, Grosvenor Square.

We have survived the second round of the Inter-Hospital Cup. To the unbiased spectator the game presented very few striking characteristics. The great tension, both physical and mental, which is incident to these competitions, detracts much from the performance of the individual. With the vivid realisation of the consequences of a mistake, one is very apt to fall into the error which should most be avoided, and it is only the knowledge that both sides alike will be equally affected that leads us to hope for ultimate victory. It would be grossly unfair to our Fifteen to suggest that they played at all up to their capabilities; they played hard and well, but we have seen much finer expositions of football by the same men. Still, from the show they made against St. Bartholomew's, we have no hesitation in prophesying the retention of the Cup in the Smoking-room.

The Nurses' Choral Society (in big type) and the Students' Glee Club (in small type) are advertised to give their Fourth Annual Concert on Tuesday, February 27th, at 8 p.m. We hope the hospital will be strongly represented on this occasion, and give moral and financial support to the two Clubs. We have not yet been supplied with a programme of the entertainment, but we hear that, in addition to the usual constituents of a Chamber Concert, there will be a number of Glees and Part-songs. It is rumoured, too, that there is to be a comic duet, but our informant here is hardly reliable. Tickets may now be obtained from members of the Committees; and we would suggest to all men in the wards that they can save themselves and others a great deal of worry by getting a ticket at once. Delay is but putting off the fatal day; you have to have them!

The Annual General Meeting of the Tennis Club will be held on Friday, February 23rd, at 4 p.m., in the surgical class room. The President, Mr. Lane will take the chair, and the usual business incidental to a general meeting, will be conducted. These general meetings, indeed all general meetings, are very sparsely attended, despite the fact that, in the case of the Tennis Club, for instance, close on three hundred men indulge in the game. There is always opportunity at these meetings to criticise, and, moreover, criticise with some ultimate hope of success, but apparently men find it more congenial and safer to murmur innuendoes to a few discreetly talkative friends than to voice their opinions in public. The Tennis Club, apparently, is mildly flourishing. First of all we had but five courts on the terrace; then we added four courts near the entrance gate. In 1897, two more courts were opened, and the Secretary hints at two more courts in 1900. Dr. Washbourn, who was as keen a vice-president as could be imagined, will be much missed this season, although he will doubtless keep up the tennis reputation of the Hospital at the Cape. We would impress upon men the advisability of attending this meeting, if only to give weight to the projected continuance of the second team.

We have received a letter from Messrs. Mellin, in which they generously offer to supply their Infants' Food gratuitously to the babies rendered fatherless in the present war. The letter goes on to say that the task of discovering orphans of this nature is so formidable that co-operation becomes absolutely necessary. They, therefore, ask us to send them the names and addresses of any cases that may come to our knowledge. Should any of our readers be able to supply such information, we shall be pleased to receive

letters and forward them to Messrs. Mellin, or they might be sent direct to the offices at Peckham, S.E.

MR. FRIPP left London on Saturday, February 10th, as announced in the last GAZETTE. Although the hour was somewhat early, ten minutes to nine, a large number of men from Guy's turned up and gave him a hearty ovation. The crowd commenced to collect at about eight o'clock, and somewhat unfeelingly demanded speeches from various railway officials of a harmless nature. By eight fifteen, quite a respectable mob had assembled, and at eight twenty, reinforcements of police were hurried up. This unfortunate circumstance prevented any demonstrations taking place on the platform, and we contented ourselves with singing "Auld Lang Syne" and the National Anthem outside the gates. Mr. Fripp evidently appreciated the cordiality of the farewell and the sympathy that prompted it for he wired from Southampton: "Please thank boys from me for the splendid send-off they gave us this morning at Waterloo. My love to them and to all at dear old Guy's."

THE remainder of the Staff and the Dressers left the Monday following, when a similar scene was enacted at Waterloo. Just before the train left the platform, three cheers were raised for "Washy," and one more was given when his smiling face appeared at the window. Much handshaking, much cheering, and then the impatient "stand away there" of the officials, and in a scene of the wildest enthusiasm, the special moved out of the station southward bound. It now only remains to send the Nursing Staff away. By the time the GAZETTE is published, this will have been accomplished, and we shall settle down to our humdrum life again, with many a curious heart-pang for the missing familiar faces.

ALTHOUGH the GAZETTE is not directly a subscriber in money or kind to the Yeomanry Hospital, we are still indirectly represented. Messrs. Ash & Company, our printers, have made a very generous donation of stationery to the stores of the Hospital. Through them, too, comes the gift of a Cyclostyle, which has been presented by the Cyclostyle Company, of Snow Hill.

WE are suffering all the discomforts of a hard frost without enjoying any of the benefits. Through some unaccountable reason, a huge main service-pipe, some four feet in diameter, cracked, burst, or blew up at Hampton and immediately put our water supply on a famine basis. As a preliminary economic measure, all the hot-water supplies were abolished and Surgeons and Dressers were forced to wash up in ice-cold water. Then, in the second stage, even this supply failed, and we are now enjoying the spectacle of men hand-pumping water from the hydrants into the surgical-building cisterns. All of which makes us long for the time when we shall be independent of external aid in light and water.

THIS however cannot account for the deplorable fact that the new Physiological buildings have been left unheated for the past three weeks. Failure of water is an excuse which will not be accepted, for the break-down in the radiator system first occurred when the water supply was admittedly excellent. The new lecture theatre is admirably constructed from the acoustic point of view, but even with its obvious advantages, the voice of the lecturer has been lost in the shuffling of his audience in its efforts to keep warm. In the laboratories, work has been positively painful and provocative of much bodily anguish and verbal heat. A high temperature —such as is found in the summer when all the radiators are in full swing—is not required. All we ask is that our hands should not be numbed by contact with metal instruments and microscopes.

IN the Library, too, the same complaints are made about deficient warming power. To begin with, the door by which entrance is gained has become so decrepit that it generally remains swung widely open. Consequently all the eddies and cross currents of the quadrangle sweep cheerily round the Library and render the mere physical task of holding one's paper down, a burden. We know that the fitful glimmer of the electric light is beyond the control of the authorities; we know that they are not to be held responsible for the breaking of mains at Hampton. But we do believe that they can and should supply warm water to the heating pipes when necessary, and replace doddering doors by draught proof structures.

TO-DAY is the occasion of the Annual Inter-Hospital Cross Country Challenge Cup Competition. The title is somewhat long, but the course is considerably longer. Guy's and St. Thomas' are the only two hospitals competing, or rather we should say, St. Thomas' is the only hospital that has had the temerity to

challenge our possession of the cup. The teams will start from the Royal Forest Hotel, Chingford, at 4 p.m. They will run for a distance of ten miles and return later in the same day. The cup will then be brought back and put in the smoking room. To add additional interest to this contest, a sealed handicap has been arranged for decision at the same time.

SOME years ago it used to be considered the thing to misbehave oneself at lectures. Violent applause, sotto-voce criticisms and kindred pleasantries always numbered a host of votaries, and at one time the nuisance assumed such proportions that the men were compelled in their own interests, to suppress the offenders. Nowadays, speaking generally, we have none of this, but to this statement there is a single exception and one which calls for immediate attention. It is quite unnecessary to specify the case to which we refer; most men will at once recognise the fact, and more exact indication would serve no useful purpose. The time has now come when these ridiculous demonstrations should cease. From whichever attitude the matter is viewed, the opinion is forced upon us that the men are hopelessly in the wrong. To begin with, the perpetrators stamp themselves as an unmannerly horde; secondly, their behaviour distracts the attention of those who are willing and capable of profiting by the lecture and finally, it is insulting to the lecturer himself. Such conduct befits more a junior form in a board school than a class of presumably scientific gentlemen.

IN another column we publish a letter received from an old Guy's man, in which he advocates the formation of a Special Hospital Corps, somewhat on the lines of irregular infantry. He enters into detail which is somewhat too minute for a preliminary project of this kind, but the very fact that such detail is introduced, shows that he has considered the subject in no light manner. The captious critic, of whom lately we have had rather more than we wish, will find ample opportunity in this letter for the exercise of his genius. But the basis of the idea is sound, and well worthy of careful consideration. If it be viewed from a purely selfish stand-point, the avoidance of conscription, it must be allowed that the plan is admirable. Other and more generous considerations add their own value to the project, apart from its utility as a means of averting general military service. We shall be glad to hear our readers' opinions, and to publish them in our columns.

DESPITE the horrible weather, two highly successful meetings were held last Saturday. At the one held at the Criterion, the Dental Society scored another success in their Annual Dinner, which realized the most sanguine expectations. The Debating Society met the same night in an impromptu debate, which was chiefly characterised by the earnest importunities of one member. His irrepressibility, his "slimness" when cornered, and his ready repartee, tended to brighten what might otherwise have been a somewhat sombre evening.

O tempora, O mores! Shades of Jewell, Collins, Jeffcoat, "K.B.," and "Freddy," have you been followed by a coterie of shining lights, who, in their zeal for their professional duties, exceed yourselves, or by a tribe of degenerates, whose only ideas of sport are poker, and the persiflage of the residents' dinner table? Joking apart, our residents are naturally regarded as the arbiters of form at the hospital, and it is somewhat saddening to see them so poorly represented at the Footer cup ties. Possibly the present times are without precedent on account of the scarcity of qualified men at the hospital, but we always regard our junior staff as our most hard-worked department, and they turn up in force, and with enthusiasm, while the residents are represented by not more than one or two. We hope for more keenness in the future, and sincerely suggest a short trip to Richmond as an excellent aid to their diagnoses and digestions.

IT was pleasant to see Jackson again on the field, and we may expect his reinstatement at half-back in the next game, as O'Brien should be sufficiently recovered to play at centre. It is to be hoped that a fractured metacarpal will not deprive us of the services of Cutler, whose nerve makes him a stimulus to the whole pack; we trust, too, that Mullins will soon be fit again, as his absence would most seriously affect the team. We must congratulate Harrison on a good all-round display which marks him as a man of coolness and resource, who will, with added experience, be invaluable to his side. Trail, too, played a sterling game, appealing perhaps less to the gallery than to the initiated; he is always ready to bear the brunt of that unseen and untalked-of defensive work, which means so much to a side when pressed. The

weather has not been conducive to much training lately, or we should perhaps have seen a better display of kicking, both drop and place. There is certainly room for improvement in this department, which must always tell greatly, both in attack and defence.

ANY men who want to see a really good, hard-fought Rugger match, should remember that the First Round in the Surrey County Cup will be played at Honor Oak to-day. Our "A" team meets the Lennox "A," and, judging by the form shown in previous years, the game is likely to be extremely interesting. From start to finish the teams will play to win, and as we hope our own lot will come out victorious, as many Guy's men as possible should turn up. Nothing helps a team like an enthusiastic sympathetic touch-line.

Obituary.

Dr. Francis Charlewood Turner.

We regret to announce the death of Dr. Francis Charlewood Turner. After nearly twenty-five years' work at the London Hospital, Dr. Turner resigned his position as physician at the beginning of this year, but was not destined to enjoy his leisure for long.

Dr. Turner was educated at Cambridge University and Guy's Hospital. He commenced his professional education in 1867, and a year later entered our School. He took the M.R.C.S. in 1871, and in the following year held the appointment of clinical assistant. In 1873 he was appointed firstly to be house-physician, and then house-surgeon. In the succeeding year he graduated M.A., M.D. Cantab, and in 1875 became M.R.C.P. London. On the 7th June, 1876, he commenced work at the London Hospital as assistant physician. Five years later he was elected a Fellow of the College of Physicians, and in July, 1891, he became physician to London Hospital. He was also consulting physician to the North Eastern Hospital for Children, and to the London Orphan Asylum.

We are indebted to the *London Hospital Gazette* for the following appreciation of Dr. Turner:—

"Space does not permit us to speak of his professional work. Briefly, his leaning was towards Pathology. In fact, in his day he was reckoned among the first Pathologists in England. He has made several valuable contributions to the *Transactions* of the Pathological Society, to the *British Medical Journal*, and other professional organs.

"Dr. Turner's personality belonged to that class of old-world doctor, whose face beamed kindness, sympathy and encouragement to his patients. His anxiety and care for his hospital patients would bring him down to Mile End Road on any day of the week, and it was almost the rule for him to come on Sundays to see how they were getting on. Like the late Sir William Jenner, there was nothing of the awe-inspiring demi-god about him, at whose approach nurses, students and patients, quake. The only 'dreadful' thing about Dr. Turner was his double stethoscope, which was always a source of wonder to the new-born clinical clerk.

"In private life, Dr. Turner was among the most charming of men. To be invited to dinner in Finsbury Square was an honour and a pleasure that was always greatly appreciated by any and all who have worked under him."

Samuel Ralph Apthorpe, L.D.S. Eng.

It is with much regret we have to record the death of Mr. Samuel Ralph Apthorpe, which event took place on January 29th, 1900, at Bromley, Kent, at the early age of 29.

Mr. Apthorpe succumbed to blood poisoning, contracted in the performance of his professional work a short time before last Christmas. He entered Guy's Hospital as a dental student in 1890, and qualified as L.D.S. Eng., in November, 1892. His career at the hospital was very successful, for he not only obtained a certificate for general proficiency as a second year's dental student, but he also held the positions of student demonstrator, assistant demonstrator of dental microscopy, and assistant dental house-surgeon, and he invariably acted conscientiously and with diligence and intelligence.

He settled in practice in Bromley, where he had previously resided, soon after being qualified, and he was steadily building up a good reputation as a skilful dental surgeon.

Mr. Apthorpe was kind and considerate to all with whom he was associated, and was thoroughly imbued with the feelings of a professional man. We offer his widow our sympathy in her sad loss, and we can assure her that it is sbared by the members of the staff and his fellow-students.

The "Hodgen" Fund.

THE following subscribed to this fund:—Member of Staff, A. Reader, F.O.S., H.L.E., P.T., W.J.L., L.E.C.H., E. W.S.R., A.H.C., E.E.P., W.T., A.H.M.S., A.R.T., C.B.T., K.V.T., G.M.B., F.G., F.M.V.S., J.A.B.H., S.H., W.W. C.T., A.E.H.P., F.E.W., P.S.M., L.G.S., N.F.T., W.B.S., A.H.D., B.S.R., A.P., L.W., F.C., G.S., J.D.D., G.T.W., I.A.R., I.A.B., H.S.T., R.M.B., J.D.P., M.I.R., F.D.S.J., H.W.P., H.W., D.F., R.I., C.H.I., I.T.W., H.A.C., L.H., A.W.T., S.L.B., W., H.C.W., D., P.B., R.G.A., R.D.B., B.T., C.H.R., A.C.R., C.C.P., M.Y.M., G.W.S., T.F.R. L.C., W.R., G.M.

Guy's Men in or going to South Africa.

The following list has been compiled as nearly correctly as possible from hearsay or inquiry. If anyone can supply omissions or correct mistakes we shall be very glad to hear from them.

NAVY.

Surgeon C. M. Beadnell, R.N., H.M.S. *Powerful* (with Methuen).
Surgeon Mourilyan, R.N.

ROYAL ARMY MEDICAL CORPS.

Lieutenant V. J. Crawford, R.A.M.C., No. 16 Field Hospital.
Lieutenant C. R. Evans, R.A.M.C.
Lieutenant L. Humphry, R.A.M.C., No. 16 Field Hospital.
Lieutenant J. Matthews, R.A.M.C.
Lieutenant H. B. Onraët, R.A.M.C., 2nd Battalion Royal Scots Fusiliers.
Lieutenant H. D. Packer, R.A.M.C., No. 10 Field Hospital.
Lieutenant Pern, R.A.M.C.
Lieutenant N. Simson, R.A.M.C., Medical Officer to Gen. Buller's Staff.
Lieutenant R. E. G. Phillips, R.A.M.C.

CIVIL.

Imperial Yeomanry Hospital.

A. D. Fripp, Esq., F.R.C.S., M.V.O.
Dr. J. W. Washbourn.
F. Newland Pedley, Esq., F.R.C.S.
Dr. H. W. Bruce.
Mr. L. E. C. Handson, M.B., B.S.
Mr. R. T. Fitz-Hugh, M.B.
Mr. G. E. Richmond, M.B., B.S.

Dressers.

Mr. A. Ayre Smith.
Mr. J. Atkins.
Mr. D. G. Greenfield.
Mr. A. Pearson.
Mr. A. C. Ransford.
Mr. Owen Richards.

Dr. E. T. Shorland, Medical Officer to the 1st Battalion Imperial Yeomanry.
Dr. A. C. Fry, Medical Officer to the Imperial Yeomanry.

Mounted Orderlies to Dr. Fry.

Mr. C. B. Sells.
Mr. G. T. Wrench.

CIVIL MEDICAL OFFICERS ATTACHED TO THE ROYAL ARMY MEDICAL CORPS.

Mr. K. B. Alexander, Field Hospital, No. 20.
Mr P. R. Lowe, M.B., Hospital Train.
Mr. S. E. Denyer.
Mr. F. E. Fremantle, Base Hospital No. 1.
Mr. J. N. Gardiner.
Mr. E. D. Hancock.
Mr. S. Copley.
Dr. C. R. Hodgson, 3rd (Militia) Battalion South Wales Borderers.
Mr. P. C. P. Ingram.
Mr. W. J. Lindsay, Base Hospital.
Mr. R. B. Stamford, F.R.C.S.E.
Dr. H. J. Starling, Base Hospital, No. 6.
Mr. F. O. Stoehr, Royal Artillery.
Mr. F. E. Walker, 3rd (Militia) Battalion Durham Light Infantry.
Mr. Stanley Whicher.
Dr. E. T. E. Hamilton, F.R.C.S., Imperial Light Horse.
Mr. W. G. Rogers, M.S., of Johannesburg.
Mr. W. T. F. Davies, of Johannesburg.
Mr. F. W. Landon.

COMBATANTS.

Captain W. A. Brailey, C.I.V.
Private J. A. Glover, C.I.V.

Imperial Yeomanry.

Trooper R. O. Moon.
Trooper T. H. Body.
Trooper C. A. E. Ring.
Trooper F. W. Featherstone.

The Out-patients' Tea Fund.

CHRISTMAS, 1899.

1899.	Receipts.	£	s.	d.
Dec.	To Balance brought forward from last year's Tea	15	0	0
	„ Subscriptions	121	15	2
		£136	15	2

1900.				
Jan. 1.	To Balance brought forward	£67	9	4

1899.	Disbursements.	£	s.	d.
Dec. 30.	By Refreshments	28	5	5
	„ Toys	10	0	9
	„ Crackers and Lights	3	12	7
	„ Tea and Bags	4	17	6
	„ Punch and Judy Shows	5	13	0
	„ Flags and Decorations	2	3	2
	„ Printing and Stationery	2	10	6
	„ Fees to Servants, Police, and Postage, etc.	12	2	11
	„ Balance in hand	67	9	4
		£136	15	2

Audited and found correct,
Jan. 17th, 1900. CHAS. H. WELLS.

It will be noticed that we carry over a balance of £67 9s. 4d. Of this balance, £30 has been given to Sister Sarah for use in the district, and £7 9s. 4d. to Sister Out-patients to buy boys' clothes. The remaining £30 was carried over to next year.

WALTER G. STEWART,
Hon. Sec. *pro. tem.*

Guy's Hospital Dental Society.

A MEETING took place on January 16th, 1900, at 5 p.m. The President, Mr. Baker, occupied the chair. The minutes of the previous meeting having been read and confirmed, two casual communications were presented by Mr. Pearce for the Secretary.

1. Hypertrophy of the gums in a paper-hanger, aged 20. The family and past history were unimportant. The upper and lower jaws, except in the left molar regions, had large lobulated masses of gum where teeth had been extracted; the gums were not tender, did not bleed easily, and no signs of inflammation were present. There was no history of pain, bleeding from the gums, or lead-poisoning. Remaining teeth were very loose; these were extracted, and three months later the condition of the mouth was markedly improved.

2. V-shaped contracted arch associated with deflected nasal septum, due to thumb-sucking; illustrated by models. The President commented upon these two cases, and called on Mr. Hopson for a few remarks on hypertrophy of the gums. Mr. Hopson responded with an interesting account of a case which had been in his care, and referred gentlemen to the December number of the "Odontological Society's Transactions" for his report of three excellent cases. Mr. Bennet was then called upon for his paper on "The Diagnosis and Prognosis of Swellings about the Mouth." A variety of specimens, both models and spirit preparations, were shown to illustrate the paper.

THE DIAGNOSIS AND PROGNOSIS OF SWELLINGS ABOUT THE MOUTH.

MR. PRESIDENT AND GENTLEMEN.—It has been my endeavour in preparing this paper to dwell on those phases of the subject which are most likely to be of use to us all in dealing with the cases that shall from time to time come under our care in private practice.

To this end I shall make a few general remarks concerning points in diagnosis, then briefly discuss some of the more common swellings in definite regions, and special cases. Of course, the main difficulty in dealing with this subject is to make a selection that will be at once interesting and useful, as the time at my disposal allows only a very small selection to be made. I shall dwell mainly on the diagnosis of each case, with brief reference to the usual treatment, and just so much notice of the prognosis as it would be necessary to lay before the patient prior to treatment. I shall not say much about treatment, because that would not be possible in the time, and in many cases it would be the work of a general surgeon.

In reading records of cases and looking over specimens in our museums the necessity for early diagnosis of a swelling and speedy treatment is forced upon one again and again. How many of the horrors now to be seen in our museums might have been avoided, how much suffering would have been prevented had the trouble been recognised and treated in time.

And so, gentlemen, it is my purpose in this paper to invite your attention especially to swellings in their *early* stages, when, indeed, diagnosis is more difficult, but when it is also more important. For when patients come to us with small swellings in our special region of the body, it seems to me that we should never rest content with a superficial survey of the condition, nor excuse ourselves from full investigation by thinking that the *teeth* only are our province. It is surprising how little valuable information some patients will offer voluntarily, so making it the more necessary for us to ask questions about the history of any suspicious appearance. With the opportunities for self-instruction that lie within our grasp as students at Guy's Hospital, the highest interest of our patients should be safe in our hands so far as oral surgery is concerned, as well as in other branches of our art. I think we are all too familiar with ordinary dental troubles to be carried away by our enthusiasm into sending a patient suffering with an open sinus from a chronic abscess caused by a dead tooth, to a surgeon for removal of necrosed bone, or any similar mistake—such as we read of happening occasionally. What *we* need to beware of is, treating things too lightly and saying: "Oh, it's only a gumboil," when proper discretion would lead us to a more thorough examination.

It is often impossible to give a correct diagnosis without first doing some slight operation, such as puncturing in the case of a cyst; this should teach us the necessity of taking impressions, before operating, of any swellings at all likely to be of interest. This necessity is shown by the lack of models of dentigerous cysts in our museum. A man opens up what he takes to be a dental cyst without thinking of taking impressions, and after he has made it impossible to take an impression, finds he is dealing with an interesting dentigerous cyst. Then he regrets that he has deprived our hospital of valuable models. On the other hand, a careful man will take impressions if he thinks a tumour at all likely to be of interest, and when he does get a true dentigerous cyst, the satisfaction will, no doubt, amply repay him for his trouble.

Taking these things into consideration, I have omitted such diseases as tuberculous infiltration of the tongue and hypertrophied conditions of that organ met with in advanced stages of lung, kidney, and intestine trouble, also very advanced tumours of all kinds, as in such cases the patient would be under medical or surgical care, and probably beyond dental treatment altogether. But I have brought for your inspection a few models and specimens of diseases in an early stage which present special points of interest in diagnosis and prognosis.

The first points are to decide whether the tumour is solid or liquid, innocent or malignant, and to define its origin and attachments. One may decide that a tumour is a sarcoma, but to say its exact nature and malignancy is impossible until microscopical examination is made; this may be done before operation sometimes, when a section can be obtained. In the case of cystic swellings puncture is often permissible to decide diagnosis. It is

wise to proceed systematically in the examination, first carefully *inspect* the tumour and surroundings, then *feel* in order to decide whether you are dealing with a cyst or a solid growth, and also carefully define the limits of the tumour as far as possible, and decide whether it is lying free in soft tissue, attached to any duct or vessel, or fixed to the bone. When the tumour is soft and fluctuating we can put it down as a cyst, dental, dentigerous, sebaceous, etc., and we must then differentiate between the various cysts. If the tumour be hard we must decide whether it is innocent or malignant. If it is of slow growth, and painless, and neither the skin nor the glands are involved, and there is no infiltration of the surrounding tissues we can say it is innocent. But a malignant tumour would be of rapid growth, painful, the skin and neighbouring lymphatic glands would be involved; also malignant tumours after a time protrude a fungoid mass into the mouth or nose, or on to the cheek, as the case may be. If a tumour be a sarcoma it will show a tendency to bleed very freely; the age of the patient will be an important guide here, sarcomata occurring in young people, carcinomata being limited almost entirely to people over forty years old, they both grow quickly and are very painful. The difference between *fast* and *slow* is well marked; thus a malignant sarcoma occurring in a child of seven may develop remarkably in a few days, and prove fatal in a few weeks if not operated on, while an innocent growth such as osteoma or chrondroma will linger for years, increasing almost imperceptibly unless roused to activity by some cause such as a blow.

The prognosis in all cases depends on how far the disease has progressed. If treated early and radically in almost every case a cure can be promised, and even in those cases where innocent growths have been allowed to attain very large size, thorough and radical removal is most likely to end successfully. In unobserved or neglected cases of malignant growths, such as carcinomata, the prognosis is practically hopeless. With swellings in the lower jaw the prognosis is good, because of the ease and completeness with which treatment can be carried out. A large part or even the whole of the lower jaw may be removed, and the patient accomplish a good recovery.

Proceeding to the study of special cases. In the first place, here are models of two cases of dental cyst. The first was thought to be possibly a malignant growth, there are three models of it, one before operation (9 Dental Museum), the second taken three years after (10 D.), the third after nine years had elapsed (10B D.). The first is described as: "A model of the upper jaw of a patient aged about forty-five, the case occurred in the practice of Mr. F. V. Mackenzie. There had been a gradually-increasing swelling of the face supposed to be malignant. Under gas an incision was made by way of the mouth, and a quantity of semi-solid cystic fluid evacuated. The cyst was connected with the root of the left lateral incisor."

The second case is a dental cyst connected with the first left upper bicuspid, it was dissected out by Mr. Symonds. The second bicuspid that side is missing, and a history of extraction not being at all clear it was thought possible that it might be a dentigerous cyst caused by the aberration of the second bicuspid. This case was under the care of Mr. Payne.

In considering cysts we have first to decide that the swelling under consideration is neither an acute nor a chronic abscess. The history of the trouble will usually be very definite and sufficient in the case of abscesses, and if any doubt should arise the treatment or removal of any tooth that might cause an abscess would clear up the difficulty. In cases where there is no apparent cause for an abscess or dental cyst a dentigerous cyst, otherwise called follicular odontome, should be thought of. If one or more teeth are missing in the neighbourhood of the tumour their history should be elicited from the patient if possible. Supernumeraries may cause them, however. There is an interesting case of dentigerous cyst represented by models here, the first (125 D) shows "models of a boy aged nine, who was operated on by Mr. Howse for dentigerous cyst ten months previous to taking models. A tooth (? left central) is seen erupting high up in the buccal sulcus." The second model shows a strange effect of displacement of the left central incisor through the cyst, the central now occupies a position posterior to the lateral. The models 201 A, B, C, were taken three years after model 125; A illustrates the condition before removal of left central, B was taken two months later, and C three months after removal of the left central, showing the course things took in this case.

(To be continued).

The Dental Society's Annual Dinner.

On Saturday, February 10th, the Society held its "Fifth Annual Dinner" at the Criterion Restaurant. In spite of the elements, which were behaving in a most unseemly way, to say the least of it, there was a large attendance; in fact, a record was established by the very large number of "one" more than on any previous occasion, still this figure would have been magnified had the weather been a little more propitious. We must be merciful too, and attribute the late hour in starting to the same cause, namely, the weather. However, the evening justified the delay, for things afterwards proved highly satisfactory and the secretary is to be congratulated upon the success which crowned his endeavours.

Mr. Baker, the president, occupied the chair; amongst his supporters were Mr. Maggs, Drs. Fawcett, Beddard, Spriggs, Silk, Mr. Badcock, Mr. Fagge, the late president, Mr Hopson, and others.

Dinner concluded, the toast of "The Queen" was proposed by the chairman, who, whilst stating that it was the last year of the nineteenth century, amidst the muffled murmurings of those still undecided upon this

point, referred to her long and prosperous reign, marked as it had been by such great progressive steps in every aspect and walk of life, professional, scientific and commercial, and during which she had secured not only the love of her own subjects but also the respect and sympathy of the whole world.

In proposing the next toast, that of "T.R.H. The Prince and Princess of Wales and other Members of the Royal Family," the Chairman mentioned the great interest taken by H.R.H. the Prince of Wales in Guy's Hospital as shown by his acceptance of the presidency of the Board of Governors and his personal visits and exertions in favour of the Re-endowment and Sustentation Funds. Both he and the Princess held a high place in the hearts of the people, and had shown in common with all the Members of the Royal Family their readiness to help in person or kind wherever help was needed.

Dr. FAWCETT proposed "The Army, Navy and Auxiliary Forces." He thought that as a nation we could not exist without war, quoting from Ruskin the passage stating that all great nations are nourished and trained by war, and that protracted peace inevitably sows the seed of their future decline; that nothing but praise was due to our military forces, and that in the near future they might obtain a hard-earned success; the medical portion he considered appealed most to us, and felt sure we must all be proud that we were sending our best men to the front, such as Mr. Fripp, Mr. Newland-Pedley, Dr. Washbourn, as well as others too numerous to mention; and recalling the brave and gallant deeds of our army in South Africa, led by our great generals, he thought we might safely drink the toast with a pride we had never felt before.

Dr. BEDDARD, in reply, spoke of the advantages Englishmen had over other people in escaping conscription, and thought the least we could do was to learn to shoot straight, and join our respective volunteer corps. He had a great admiration for army surgeons, who required to be good physicians, good surgeons, and in addition had to do the dental work of the army. He feared the dental part of Tommy Atkins's anatomy was grievously neglected, and hailed with delight the appointment of Mr. Newland-Pedley to the Imperial Yeomanry Hospital. In spite of our checks, as Englishmen we should feel thankful that our army had done as it had, and should show our gratitude by offering our services medically and dentally. We could but feel proud of the way in which all our men had upheld the best traditions of the British race.

The Chairman proposed "Guy's Hospital: The Medical and Dental Schools." He went on to speak of his great admiration for Guy's and thought there was no need for him to mention the affairs of the hospital, a period of prosperity had set in, thanks to the energy of the President, Governors, Treasurer and others. In all his association with the dental school he could but speak with gratitude for the kind and general assistance he had always received from the medical staff. He was glad to say that dentals had played a prominent part of late in the hospital sports, and that Messrs. Dowsett and Simpson had obtained, the one a senior prize in the medical school, and the other the treasurer's gold medal for clinical medicine, and also that as many as thirty dentals had volunteered for the front.

Dr. SPRIGGS replied in the absence of Dr. Taylor and is to be congratulated for his excellent speech at such a short notice. The "Dental Society," was proposed by Mr. Fagge, who congratulated it upon its progress, and in conclusion made a touching reference to Mr. Davies-Colley, who proposed the toast in 1899.

Mr. DOWSETT, in reply, whilst regretting the absence of Mr. Wynne Rouw, thanked Mr. Fagge for the kind way he had proposed the toast, announced that the Society was in a flourishing condition, and hoped that members will lend their liberal support in the future as they had done in the past.

Mr. GOADBY, proposing the "Visitors," remarked on the large number present, but regretted the absence of Drs. Taylor, Shaw and Washbourn, Mr. Davies-Colley, Mr. Howse and Mr. Lucas. He praised the enthusiasm of the members, amongst whom he noticed one from Aberdeen.

Mr. HOPEWELL SMITH responded, and amongst many other good things commended to the Society some lines of Longfellows', in which your reporter became lost. He revived again, however, just in time to catch the fading words of Mr. HOPSON, who had been proposing the health of the Chairman. The latter made a short and appropriate reply, thanking those present who had so kindly contributed to the success of the evening, and concluded by proposing the health of the Secretary,

Mr. LIONEL PRALL, who responded amidst cheers, and, after mentioning others, especially thanked the medical directors and artists who had so materially contributed to the success of the evening. "Auld Lang Syne" then terminated the festivities.

Some excellent musical items were rendered between the toasts, Messrs. H. T. Campkin, E. W. Corfe, Tom Godfrey, Sydney Jones, Hopewell Smith, J. Pilcher, W. and E. Rowlett, and R. Manning taking part.

Nursing News.

MATRON'S OFFICE.

Miss Ella Laurence, (Sister Charity) is leaving shortly for South Africa, to take charge of the hospital which is being equipped by Mr. Moseley.

The change of wards has taken place, Lydia going up to Dorcas, and Dorcas coming down to Lydia. Naaman and Job also change places.

Miss Cawley, (Sister Lydia) will succeed Miss Laurence as Sister of Charity Ward, and Miss Constance Symons who completed her three years' training in October last, and has since obtained her L.O.S., has been appointed Probationary Sister of Dorcas Ward, which owing to the changes, becomes vacant.

Novelties.

THE "INFANT AND INVALID" FOOD.

IT has often been a matter of wonderment why, among the complexities of infant foods, space was not found for a natural farinacious food. The lesson which might have been learnt from the Scotch peasant and his staple diet of porridge has been generally ignored. In the case of the "I. and I." Food, however, the Infant and Invalid Food Co., Ltd., have made an attempt to return to the older if less fashionable ideal, with, we think, a very considerable amount of success! This food which is registered as the "I. and I." Food, forms essentially a cooked cereal diet, in which various natural foodstuffs are blended with a view to obtaining the most easily digestible whole. There has been no attempt at predigestion; indeed, the inventors claim this as a special advantage, holding, we think rightly, that predigested foods tend to produce a state of unhealthy inactivity in the digestive organs. Cellulose and non-absorbable mineral matters are reduced to a minimum, as will be seen by references to the following table of analysis:—

Water	8·03
Fatty Substances	3·55
Albuminoids	13·19
Carbohydrates	72·03
Residue	3·20
	100·00 per cent.

We have tried the food on a number of patients, both adult and children, with uniformly good results. In the case of the children more particularly, no difficulty is experienced in getting them to take it. Indeed, children positively like the food. We had no instance of any digestive trouble arising after its use, and the children showed that general healthy appearance concomitant with proper feeding. We have no hesitation in recommending this food.

Address to be presented to Mr. Davies-Colley.

J. N. C. DAVIES-COLLEY, ESQ., M.A., M.B., M.C. Cantab, F.R.C.S. England.

"WE, the undersigned past and present students of Guy's Hospital, desire to convey to you our heartfelt admiration for your long and invaluable work amongst us, both as a Surgeon and a Teacher; to express our gratitude for the example which you have so constantly set us, of devotion to duty, sterling honesty of purpose, uprightness and integrity; finally we would affectionately assure you that the breaking of the official ties which bound you to us has occasioned the deepest personal sorrow and regret."

The above constitutes the text of the illuminated address at present in course of preparation. Signatories should immediately send in their autographs, which will be copied into the body of the address. We would invite every Guy's man to sign this address and help us to make it as representative as possible. Perhaps this is the most fitting place to record the words with which Mr. Lucas commenced his duties as lecturer on surgery, in succession to Mr. Davies-Colley.

"As this is the first time I have had the honour of appearing before you as lecturer on surgery, I do not wish to conceal from you the responsibility I feel in succeeding to a chair which has been held by so many distinguished—I may say illustrious—surgeons in former years. I could have wished to have succeeded to it under different circumstances, for as you are aware, the immediate cause of my being called upon to give this course is the retirement through ill health of my esteemed colleague, Mr. Davies-Colley. You all know him and can appreciate his worth. But you cannot know him as I have known him, for I have worked with him side by side—I might say, shoulder to shoulder—in all good fellowship for upwards of thirty years.

"A genial fellow-student and a most loyal colleague, Mr. Davies-Colley could always be relied upon to do thoroughly and earnestly whatever he undertook. I cannot tell you how deeply I regret his retirement, and I know how you will miss his sound clinical teaching in the wards, and his unselfish work on your behalf. This is certain, that Mr. Colley will carry with him in his retirement the good wishes of all those who have ever known him, and we shall all unite, students, staff and old Guy's men, in hoping that rest from his arduous hospital duties may prove of permanent benefit to his health."

An Old Letter.

WHILE overhauling some old hospital documents, the following curious old letter was found. It is here reproduced in the original orthography which is quite as quaint as the subject with which it deals. The letter is dated from Lexden, a little village near Colchester in Essex, and at a time when Samuel Sharp was Chief Surgeon at Guy's Hospital:—

To John Hollester Esq.
Tresher of Mr. Geyes Hospetell.

Sir
I am Desered by ouer Gentlemen of Coulchester to Troubell you whith this to Deser that you woold ples to admitt too poore Boyes into Hospetell to Be Cutt for the Stone thay will be thare on throsday morning and I will Give a Letter by tham to Mr. Green If the Cuting Ward at Gyes shoold be full you will ples to order tham to St. Thomas In which you will very much oblige

Your most Ready & obedent
Humb Sert to
Comand
H. Bevan

Lexden, Sept. 9. 1740.

Central Africa.

A CORRESPONDENT has sent us the following extracts from letters received from Dr. Robert Howard, who, it will be remembered, left Guy's some time since on a medical mission to the Nyanza district:—

Dr. Howard sailed with other members of the Universities' Mission down the East Coast as far as Beira. From there they went to Chinde at the mouth of the Zambesi. Here they got into another boat and went up the Zambesi and Shiré rivers to Katingás. At this place the traveller gets out and journeys overland, partly by mule cart and partly by "machila"—a sort of stretcher carried by four porters. A halt was made at Blantyre, where Dr. Howard visited the malaria commission and examined mosquitoes' stomachs. He also went over the mission which is planted there, and expressed much admiration for its work. "Blantyre," he says, "is a lovely place as far as situation goes, *but it is terribly Scotch.*"

Dr. Howard went out shooting with two native boys, and the boys lost their way in a forest. "I found they were going round in a circle, and were taking shots at trees which they thought they knew. In fact, they had clean lost their way. I had not troubled to take my bearings before we started, as I had never thought of such an occurrence. However, I knew the general direction of the river was north and south, and that we had landed on the right bank, hence the only thing to do was to take a bee line west and trust to hitting the river somewhere. So we started west by the sun, in exactly the opposite direction to that in which the boys had been leading us. The effect of will is quite curious; when the boys saw I had made up my mind to go one way they quite acquiesced that it was the right way," and this proved to be so. Finally, Dr. Howard came to the upper waters of the Shiré and finished the journey to Lake Nyassa by steamer. From there he was sent to Liluoma, an island near the east coast of the lake. The entire journey from London took one day under eight weeks. At Liluoma, Dr. Howard has been working hard at arranging his hospital and dispensary. He does not seem to have had very much strictly medical work to do. "Jiggers" and ulcers seem to be the most frequent cases. He also mentions a successful operation for inverted eyelids in a boy (the bishop gave the anæsthetic), a case of heart disease with dropsy which ended fatally, and some cases of malaria. He has also been down with malaria himself, but will not admit a bad attack, though he allows that life at 102° is a bore. In his case the attack lasted thirty-six hours. When opportunity arises he goes round the lake in a steamer and collects cases from the neighbouring villages. But in the absence of very much medical work, he has been kept busy by turning his hand to every other trade in which men were wanted, either through someone going home or falling sick, *e.g.*, he has been carpenter, chief mason, architect, boat builder, and barber. He thinks he will be able to get plenty of cases in his hospital as soon as arrangements can be made for him to make more frequent tours round the native villages to fill up his beds.

Reviews.

A Handbook of Nursing. By M. N. Oxford (Sister of Philip Ward, Guy's Hospital). (Methuen & Co.) 6s.

This most excellent work should prove a very acceptable addition to any nurse's library. The course of lectures on nursing which are delivered annually to the Probationers of Guy's Hospital by the authoress, with those on medicine and surgery by members of the Staff, are included in this handbook.

A chapter on Ophthalmic Nursing is specially interesting.

Very sound advice is given to the new Probationer who is apt to start her hospital career with somewhat strange illusions with regard to the menial duties in common with wardwork. By studying this book these illusions cannot fail to be at once dispelled.

Busy nurses will appreciate the concise and clear style in which it is written, while the glossary of medical terms is also extremely useful for reference.

If we might offer a suggestion, it is that the somewhat cheap and decidedly flimsy binding should in a future edition be replaced by something worthy of the excellent matter contained within the covers.

Also received, The Infectivity of Malignant Growths, by G. Bellingham Smith, M.B., B.S., F.R.C.S., and J. W. Washbourn, M.D., F.R.C.P.; Le Mois Médico Chirurgical; Hospital (2), Treatment, Clinical Journal (2), Stethoscope, Broad Way, London Hospital Gazette, The Owens College Magazine.

From the Gazette's Special Pathologist.

C. G. R., HALSTEAD.—This nodule is composed largely of young inflammatory tissue, with an abundance of dilated lymphatics. Possibly it represents a lymphangioma which has become inflamed. There are no indications of malignancy.

R. C., WINDLESHAM.—Tubercle bacilli are present in the sputum, in fair numbers.

R. B., RICHMOND, YORKS.—No tubercle bacilli could be found in the sputum. It is muco-purulent and contains a considerable number of red blood discs, together with numerous epithelial "squames" from the mouth and some cells from the upper part of the respiratory tract.

PATHOLOGIST.

Papers by Guy's Men.

Day-Terrors (Pavor Diurnus) in Children. By George F. Still, M.A., M.D. Cantab., M.P.C.P. Lond.—*Lancet*, 3rd February.

Sport.

Rugby Football.

GUY'S v. ST. BARTHOLOMEW'S.—INTER-HOSPITAL RUGBY CUP.

(GUY'S, 6 POINTS; ST. BARTHOLOMEW'S, NIL).

We successfully negotiated the second round of this competition on Tuesday, 6th instant, when we met and defeated a strong team from St. Bartholomew's. Monday night's thaw, followed by a strong drying wind, put the ground in very fair condition, and the game was, for a cup-tie, very fast and interesting; sometimes too much so for our supporters, who turned up in good force, but were still out-numbered by the following of our rivals.

Mullins lost the toss, and kicked-off against the wind, and a poor return on Marshall's part left the game in Bart.'s twenty-five; but though we pressed hotly, their defence was good, and a smart run and kick by their left wing relieved the pressure, and a fine forward rush put our men on their defence. Bart.'s forwards were much the heavier lot, and heeling out well, they made things very uncomfortable for us for about ten minutes. Mullins wisely took Thomas out of the scrum to strengthen the backs, and by good tackling, we saved a score, being much helped by the over-eagerness of our opponents, who almost invariably spoiled their chances by kicking too hard. By a good rush in which Mullins, Manson and Lawry were prominent, Guy's worked the game beyond the half-way line, but Bart.'s made good use of the strong wind, and got in some long kicks, one of which was finely taken by Harrison with a following catch, though hampered by the sun in his eyes. Play was now of a typical cup-tie character, and, in the friendly exchanges which took place, Louisson received some damage to his knee, which rather took the life out of his game. Mullins and Cutler also had to leave the field, the latter with a fractured metacarpal, and had they not both resumed play with undiminished vigour, it is doubtful whether we should have pulled the game through. Damage to Adams, who was playing a fine game for Bart.'s, somewhat equalised matters, and half-time arrived with no advantage gained by either side.

On resuming, our forwards went off with a fine rush, and showing more cohesion than in the previous play, soon became aggressive, but we lost ground on two or three occasions, owing to free kicks given against us, chiefly for off-side play by Thomas. Unsuccessful shots at goal were tried from almost impossible positions, but our backs got in some good returns, and Thomas atoned for previous mistakes by picking up well, and giving a pretty pass to Sime, who scored rather far out on the left; Morgan took the kick, but failed to gauge the windage, and though the attempt was good, the ball just swerved outside the posts. Soon afterwards, Sime cleverly taking a pass with his right hand, put in a short punt and raced Marshall for possession, the wind, however, took the ball too far, and it was kicked out of bounds. Our side was now showing more of its true form, and the substitution of Jackson for Brown at half, was a good move, though the former was still off-colour from his long rest. Harrison, who had been playing a fine game throughout, just missed scoring himself, as following up a good kick, he tackled Marshall right on the line. We pressed Bart.'s hard for some time, and their forwards showed marked want of staying power, while the backs found kicking up the wind no easy matter; one such attempt on the part of their full-back, was charged down well, and Wall, picking up smartly, scored on the right; but Morgan, though his kick was good, failed to increase the score. Manson and Wall each narrowly missed scoring after this, but time was called with Guy's still pressing, and victors by 2 tries (6 points) to nil. Team:—

GUY'S.—E. M. Harrison (back); F. W. Sime, C. D. Pye-Smith, F. D. S. Jackson, E. Morgan (three-quarter backs); M. G. Louisson, S. C. Brown (half-backs); R. C. Mullins, D. H. Trail, T. P. Thomas, H. A. Cutler, P. T. Manson, K. V. Trubshaw, A. H. E. Wall, R. C. Lawry (forwards).

REMARKS.—It was unfortunate that O'Brien was unable to play owing to damage sustained in the George's match, but C. D. Pye-Smith pluckily turned out, and did not seem much handicapped by a marked inequality of his pupils. Of the three-quarter line, which at times showed good combination, Morgan and Sime were the pick; the former saved certain scores on more than one occasion, by dogged following up and smart tackling. Sime, too, played in something like his old form, and was good in the attack, but failed miserably with his kicks in the first half. Jackson was palpably short of work, though he tackled with his usual vigour. Harrison, at full-back, played, in our opinion, the best game on the ground, he took the ball well, kicked with judgment, and tackled finely, showing an utter absence of that flurry which has, at times, marred his previous efforts. Louisson and Brown at half had a heavy lot of forwards to reckon with, both were good, but somewhat slow in getting the ball away from the scrum. With the forwards we were disappointed, for though they won the game, they did not play up to our expectation. Individually they were good, but individuality in a forward is of little use, and it was not till late in the game that they got together, and admirably worked by Mullins, wore down their heavier opponents. As a rule, they were slow in getting the ball out, but, when once they got it away, they kept it well at their feet, and showed none of their opponents' desire to throw away chances by hard kicking. Their tackling was good, except on the line-out, when more than once they failed to mark their men. Thomas's skirmishing game did not come off when we were being pressed, but, as usual, when our turn came for attack, he was very dangerous. Manson showed up finely in the loose rushes, and Trail played an admirable defensive game; while, of the others, all of whom were, as I have said, individually very good, Wall and Lawry both showed advance on their late form.

Association Football.

GUY'S v. ST. BARTHOLOMEW'S.—INTER-HOSPITAL ASSOCIATION CUP.

(ST. BARTHOLOMEW'S, 2 GOALS; GUY'S, 1 GOAL).

This tie was played on the Richmond Association Ground at Richmond, on Friday, February 2nd, and after a fast and keenly contested game, resulted in a win for Bart.'s by 2 goals to 1.

Guy's won the toss and elected to play with the wind and up the slope. Snow fell throughout the game, and rendered the surface of the ground very slippery, which handicapped the players to a great extent. Bart.'s kicked-off, and at once made tracks for Guy's goal, their forwards thus early displaying good combination and a fine turn of speed. They met, however, with a very sturdy defence, and the ball was returned to mid-field. Play ruled very fast, and both goals in turn were threatened, but the danger was averted. During a hot attack on Guy's goal, Ward had an excellent opening, but shot over. From the goal-kick, Barber obtained possession and made a very smart run, but his final effort went behind. A corner fell to Bart.'s, which being well placed, resulted in a goal which Wadson might have saved. Stung by this reverse, Guy's redoubled their efforts and pressed hotly, and the Bart.'s custodian had an anxious time. He saved very smartly, especially a red hot one from German, and another from Barber. Weak play by Morris lost Guy's two golden opportunities, but keeping up the pressure, their efforts were at length rewarded, Barber, after a fine run, scoring with a magnificent cross shot. Both sides strove their utmost to gain the lead, but half-time arrived with the score 1 all.

On re-starting, Bart.'s, aided by the wind, for a time pressed, but settling down to their work, Guy's improved and more than held their own. Strive as they would, however, they could not penetrate the defence opposed to them, the Bart.'s backs playing a very vigorous game. Wiltshire and Barber were playing well, the latter having very hard lines with two fine shots, which just skimmed the cross-bar. Chignell at length shot into the net, but the whistle had gone for off-side—a very doubtful decision. Bart.'s then attacked, but Robson, Edey and German were very safe, the latter bottling up Marrett, the Bart.'s speedy left-winger. Guy's hereabouts experienced hard lines, Edey, their left back, being injured, which necessitated his leaving the field. During his absence, Bart.'s gained the lead, the ball being rushed through from a long dropping shot, which Wadson should have cleared. Guy's redoubled their efforts, and certainly deserved to score, but luck was against them. The play ruled fast and furious, both sides putting in a lot of work. Bart.'s pressed, and Wadson cleared finely from a red hot shot from O'Brien; then Guy's broke away, and Barber came away with a clear field, but was hauled up for off-side, a decision which gave great dissatisfaction. Edey here pluckily resumed playing, although in evident pain. Play became rather rough, but although considerably the lighter team, Guy's quite held their own. A fine run by Wiltshire and Barber, resulted in the latter shooting behind. The whistle sounding shortly after, left Bart.'s lucky winners as above stated.

Both teams played well, Bart.'s front string all doing excellently, their combination and speed threatening danger time after time; Masterman at half, and Fowler at back, playing finely. For Guy's, the halves and backs all did well, German, at half, being especially noticeable, whilst Robson and Edey played a sturdy game at back. Of the forwards, Wiltshire and Barber outshone the others, Barber being quite the best forward on the field. Wadson in goal was unlucky, and he made several smart saves, but should certainly have saved one at least of the goals scored against him. Team:—

GUY'S.—S. P. Wadson (goal); W. M. Robson, T. Edey (backs); H. B. German, N. P. Shepherd, H. Bacon (half-backs); T. A. Chignell, H. Barber, H. P. Wiltshire, E. L. Norton, F. Morris (forwards).

Appointments.

Obstetric Resident (from April 1st).—Mr. W. H. M. Telling.

NAVAL AND MILITARY.

Staff-Surgeon EDWARD R. D. FASKEN has been appointed to the *Medusa*, Surgeon PERCIVAL M. MAY to the *Mildura*, and Surgeon ARTHUR E. KELSEY to the *Royal Arthur* for the *Ringarooma*.

Lieutenant-Colonel FAIRLAND, A.M.S., retired pay, joins the Home District for temporary duty as a Recruiting Medical Officer. Lieutenant RICHARD E. G. PHILLIPS, R.A.M.C., is promoted to be Captain.

Dr. A. CRADOCK FRY is appointed Medical Officer with the temporary rank of Captain to the Imperial Yeomanry, and Dr. A. C. ELLIMAN is appointed Acting-Surgeon to the 1st Cadet Battalion the Queen's Royal West Surrey Regiment.

Marriage.

EAST—TRIGGS.—On February 3rd, at Holy Trinity, Bishop's Road, Paddington, by the Rev. Edwin Allwright, M.A., William Norwood East, M.B. Lond., M.R.C.S., L.R.C.P., of Portland, Dorset, son of W. Quartermaine East, to Linnie, only daughter of Mrs. Triggs, of 133, Westbourne Terrace, W.

Death.

TURNER.—On February 2nd, at St. Leonards, Frank Charlewood Turner, M.D. Cantab., F.R.C.P., Physician, London Hospital, of 15, Finsbury Square, and Warren Wood, Wrotham, Kent, aged 56.

ED.—S. H.

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Calendar of Coming Events.

March, 1900.

Sat. 3.—1 p.m., Clinical lecture by Dr. Taylor.
Messrs. Jacobson and Fripp's take-in; Drs., E. C. Bevers and C. R. Howard; Cl., D. S. Greenfield.
G.H.P.P.S.—Pathological Meeting.
G.H.R.F.C., II.—Streatham, away.
III.—Southwark A., away.

Mon. 5.—Exam. for Arthur Durham Dissection Prizes.
1.15 p.m., Clinical lecture by Mr. Higgens.
Dental Test Exams. for Revision Classes begin.

Tues. 6.—Application to Medical School Office for Schedules for the 1st and 2nd Conjoint Exams. to be made not later than this date.

Wed. 7.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.

Thurs. 8.—Messrs. Howse and Symond's take-in; Drs., T. H. B. Dobson and D. R. T. Griffiths; Cl., F. G. Cross.
G.H.C.U., Address by Professor Handley Moule, D.D.
April Appointment List closed.

Sat. 10.—1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I.—Richmond, away.
II.—Marlboro' Nomads, away.
III.—Sidcup A., away.
IV.—Sidcup III., away.
G.H.A.F.C., II.—Central Technical College, away.

Mon. 12.—Revision Classes L.D.S. Eng., begin.
1.15 p.m., Clinical lecture by Mr. Laidlaw Purves.

Tues. 13.—Meeting of the Dental Society at 4.30 p.m.
Schedules for Final Conjoint Exam. to be left at the Medical School Office not later than this date.

Wed. 14.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.

Thur. 15.—Messrs. Lucas and Lane's take-in; Drs., N. F. Ticehurst and F. W. Sime; Cl., O. Marriott.
G.H.C.U.—Address by Rev. Prebendary Webb-Peploe.

Sat. 17.—1 p.m. Clinical lecture by Dr. Taylor.
G.H.R.F.C., I.—London Irish, away.
G.H.P.P.S., Treasurer's Prize Essay on "The Surgical Treatment of Gastric Ulcer."

Guy's Hospital Gazette,

MARCH 3, 1900.

Spleno Medullary Leuchæmia.

CLINICAL LECTURE BY Dr. BRYANT.

January 20th, 1900.

Gentlemen,—I have a patient suffering from Spleno Medullary Leuchæmia under my care in John ward at the present time, and I have chosen this case as the subject for my clinical lecture to-day. I will first read you an account of the case, derived from the carefully prepared report of Mr. Greenfield, and will then demonstrate to you the physical signs and discuss the diagnosis.

The patient is a man, fifty-five years of age, a cooper, who was admitted under my care on January 9th, 1899, for swelling of the abdomen and pain in the left flank. The family history does not reveal anything of importance.

Personal history.—He has worked as a cooper ever since he was seventeen years of age. He has been a heavy drinker, taking from five to six pints of beer per diem. He has never suffered from syphilis, he has not been abroad and has not suffered from malaria.

Previous illnesses.—He states that he has been feeling out of sorts for quite a year. About July last he noticed that his abdomen was swelling, and a few weeks afterwards he had slight pain in his left side. In August the pain became more acute, he was also short of breath, and, in consequence, had to give up his work. He was treated by a doctor for a short time, and was then recommended for hospital treatment. On October 25th he was admitted under Dr. Pitt into John ward. His abdomen was distended, and an abdominal tumour was found on the left side similar in character and extent to what he now has. An occasional rub was then heard over the tumour when he took a deep breath. The urine was 1020, and contained a trace of albumen. He did not look

pale. The blood was examined with the following result:—

Hæmoglobin, 50 per cent.
Red corpuscles, 76 per cent., *e.g.*, 3,800,000 to c.m.
White corpuscles, 222,500 per c.m.
Differential count of the white corpuscles.
Myelocytes, 41 per cent.
Polymorphic cells, 45·1 percent.
Eosinophilic, 2·8 per cent.
Lymphocytes, 11·87 per cent.

He was treated with quinine and arsenic, and improved considerably. Dr. Pitt diagnosed Spleno Medullary Leuchæmia.

After his discharge, on November 11th, he felt so much better that he thought he was cured. Three weeks afterwards he again had pain in his left side, and he became short of breath. His feet have slightly swollen, and he has lost two stone in weight. There is no history of any hæmorrhage of abnormal character.

Condition on admission.—January 9th.—He was rather emaciated. The lips and the mucous membrane of the gums were pale. There was no swelling of the feet. The abdomen was distended, and a large tumour could be felt on the left side presenting the characteristic signs of a splenic enlargement. The liver dulness extended one inch below the costal margin, but the edge could not be felt.

Respiratory system.—A few râles were heard at the bases of the lungs. On the left side dulness commenced behind at the eighth rib.

Circulatory system.—A faint systolic murmur, probably hæmic, was audible at the base.

The blood.—It was thin and rather paler in appearance than normal.

Hæmoglobin, 40 per cent.
Red blood corpuscles, 1,900,000 per c.m.
White blood corpuscles, 256,000 per c.m.
Differential count of the white corpuscles—
Myelocytes, 51 per cent.
Eosinophilic myelocytes, 4·5 per cent.
Polymorphic cells, 36 per cent.
Eosinophilic, 5·5 per cent.
Lymphocytes, 3 per cent.

A good number of nucleated red blood corpuscles were also found.

Some slightly enlarged glands could be felt in the posterior triangles and axillæ.

There were no retinal hæmorrhages.

Urine 1020, urea 1·2 per cent., albumen 1 part per 1000. No sugar.

The diagnosis of spleno medullary leuchæmia was confirmed. Mist. Arsenicalis ℥ j. t.d.s. prescribed. (Liq. Arsenicalis ♏v.)

The man to-day is practically in the same condition as he was when admitted on January 9th. I hope to have the patient here presently so that I may demonstrate the physical signs to you. He is anæmic, his lips and gums are pale, and he is thin. Mr. Greenfield has mapped out on the patient's abdomen the outline of the spleen, and I shall be able to show you the following points when the man comes in—

(*a*) His abdomen is distended.

(*b*) The distension is not quite uniform, there being more bulging on the left side, especially in the left hypochondriac and left half of the umbilical regions.

(*c*) There is an indistinct kind of ridge visible, running from the left costal margin, close to the left border of the sternum, to about three-quarters of an inch to the right of the umbilicus.

(*d*) When he takes a deep breath there is a distinct movement downwards of the prominence on the left side.

(*e*) When I place my hand on the abdomen I can feel a large, hard, smooth and somewhat tender tumour on the left side which extends from the left costal margin to within an inch of Poupart's ligament.

(*f*) The tumour is close up against the abdominal wall.

(*g*) Internally the tumour has a well-defined, hard, slightly rounded edge which commences above, just to the left of the ensiform cartilage, passes downwards with a slight convexity to the right, reaching a point one and a half inches to the right of the umbilicus, and then slopes away again to the left to within one inch of Poupart's ligament.

(*h*) A well-defined notch can be felt in the edge, just above the level of the umbilicus.

(*i*) When he takes a deep breath the tumour can be felt to move downwards.

(*k*) The tumour comes down so close under the costal margin that the hand cannot be placed between it and the costal margin, and further, its upper limit cannot be defined by palpation.

(*l*) Posteriorly it does not fill out the loin.

(*m*) No intestine can be made out in front of it either by palpation or percussion.

(*n*) On percussion it yields a dull note; the dull note obtained over the abdominal tumour is directly continuous with an increased area of thoracic dulness, which extends up as high as the seventh rib in the axilla, and the sixth rib in the nipple line.

(*o*) Behind, on percussing the loin, a resonant note is obtained, showing that the colon has not been displaced.

No bruit or rub can be heard on auscultation.

When you come across a tumour in this region, the first consideration must be to determine whether it is an enlargement of the spleen or of the kidney. It is extremely difficult sometimes to say from a superficial physical examination if the enlargement is splenic or renal. I shall now point out to you the chief differences. I have told you already that this is an enlarged spleen, and I will now run through the various points we have made out from the physical examination, and contrast them with the signs associated with an enlargement of the kidney.

(*a b*) Both conditions may cause a local bulging on the left side of the abdomen. In the case of considerable kidney enlargement, however, the loin is usually bulged more, and the most prominent part of the tumour is lower.

(*c*) No ridge can be seen in the case of a kidney enlargement. I remember, however, seeing once, in a case of sarcoma of the kidney in a child, causing enormous enlargement of the left kidney, a distinct cylindrical-shaped body lying over the front of the tumour; it was very distinct on account of the extremely thin abdominal wall. On palpation it could be rolled over the anterior surface of the tumour, and could also be felt to distinctly contract under the hand. It was the descending colon lying in front of the enormously enlarged kidney.

(*d*) A kidney tumour may move downwards when the patient takes a deep breath, but it does not move nearly so much as an enlarged spleen. This, of course, is due to the fact that the spleen is in such close relationship to the under surface of the diaphragm.

(*e f*) A kidney tumour is more deeply situated in the abdomen, and does not give the idea that it is in such close apposition to the abdominal wall as a splenic enlargement does.

(*g h*) A kidney enlargement has no well-defined edge and no notch, but presents a general rounded conformation.

(*i*) On palpation a kidney tumour does not move to such an extent as a splenic enlargement when the patient takes a deep breath.

(*k*) A kidney tumour generally slopes away towards the ribs, so that the hand can be placed between it and the costal margin. But in this present case, as I have already indicated, the tumour comes down close under the ribs, so close in fact that the finger cannot even be inserted between it and the costal margin. That is an important point in distinguishing between tumours of these two organs.

(*l*) Posteriorly a kidney tumour fills out the loin, which feels very firm and resistant.

(*m*) Occasionally the colon can be felt lying in front of a renal enlargement.

(*n*) A kidney enlargement often gives a resonant note on percussion anteriorly, on account of the position of the colon, which has been pushed forward by the enlargement of the organ and lies in front of it.

(*o*) Behind, on percussing the loin, the note is dull, as the colon has been pushed forward and its position is taken by the solid kidney tumour.

(*p*) Occasionally a systolic bruit can be heard over an enlarged spleen. I have heard it in two cases of enlarged spleen secondary to cirrhosis of the liver.

It may perhaps appear to be a simple matter to distinguish enlargements of the spleen and kidney when there are so many points of difference. In the majority of instances a careful attention to the physical examination, and a critical investigation of all the points I have drawn your attention to will suffice. There are, however, instances in which it is impossible from a mere physical examination of the abdomen only, to say whether the tumour is an enlargement of the kidney or the spleen. Such an anomalous kidney tumour, however, is most likely to be mistaken for a leuchæmic spleen, and this can only be distinguished by a careful blood examination. The detection of leucocytosis, even to a marked degree, is not sufficient, however, as this may occur with kidney disease. It is necessary to make a differential count of the leucocytes. I shall illustrate my point by relating to you a case of pyonephrosis and perinephric abscess I saw at my out-patients in the beginning of April last year.

The patient was a woman, aged fifty-six. She sought advice for pain and swelling in her left side, just below the ribs. She was married and had one child fifteen years of age. She stated that she had had pain in her back ever since adult life. About the middle of March, 1899, she felt very ill and prostrate. She consulted a doctor, who examined her and told her there was some enlargement of her left kidney. On April 17th I saw her at my out-patients. I examined her abdomen and found a large swelling occupying the left hypochondriac, left lumbar, and left half of the umbilical region. On palpation, it was tender, and a fairly well defined hard rounded edge could be felt extending from the ninth left costal cartilage downwards, and inwards towards the umbilicus, to a point about

one inch below that point. On percussion a dull note was elicited over the front of the tumour. It could be well palpated bimanually as it extended far back into the loin. This last sign made me think it was renal. The dull percussion note which extended upwards into the thorax made me think it was splenic. I examined a fresh specimen of blood, and found an enormous increase in the number of white blood corpuscles; they appeared to be in the proportion of one to eight or ten red. This examination of the blood made me still more think that she was suffering from leuchæmia. She was admitted under Dr. Taylor, and on May 22nd she died. I performed the necropsy and found a pyonephrosis and a perinephric abscess; the primary cause of which was a small calculus which I discovered in the pelvis of the left kidney. The abscess had opened into the colon at the splenic flexure; it was bounded above by the spleen, anteriorly and externally by the abdominal wall, and internally by the colon.

Cabot also writes, when discussing the diagnostic value of blood examinations, that "tumours of the spleen, and more especially of the kidney, are very apt to be mistaken for leuchæmia. Within a single year I have been asked to examine the blood in three cases of leuchæmia, all of which turned out to be malignant disease of the kidney. In all of these there was a large tumour resembling the spleen in the left hypochondrium, and a very large increase of white cells. In two of them the blood was examined fresh, and the great number of white cells in the slide taken as evidence confirmatory of leuchæmia. The stained specimen, however, showed only marked leucocytosis with 90 per cent. of adult cells of the ordinary type, and no myelocytes. Other large tumours of this region show similar results." In the case I saw at my out-patients, I have no doubt that if we had taken a film of blood and stained it, we should have found that the excess of the white blood corpuscles was due to an increase of polymorphic cells or of eosinophilic cells only, which observation would have with certainty excluded leuchæmia.

At this stage of the lecture, the patient was brought in and the lecturer explained the case in accordance with the condition and physical signs already described.

Having concluded, proceeded the lecturer, that the tumour is an enlargement of the spleen, the next consideration will be to determine the nature of that enlargement, and to do this you must have a knowledge of all the possible causes of enlargement of that organ, and the symptoms and signs which are associated with each.

The following is a list of the causes of enlargements of the spleen:—

1. Active congestion
   - (*a*) Typhoid fever.
   - (*b*) Typhus.
   - (*c*) Ague.
   - (*d*) Variola.
   - (*e*) Scarlatina.
   - (*f*) Diphtheria.
   - (*g*) Relapsing fever.
   - (*h*) Erysipelas.
   - (*i*) Puerperal fever.
   - (*k*) Septicæmia.
   - (*l*) Anthrax.
   - (*m*) Pneumonia,
   - (*n*) Influenza, &c.
2. Passive congestion from portal obstruction
   - (*a*) Thrombosis of the portal vein.
   - (*b*) Pressure on the portal vein by adjacent tumours, *e.g.*, of the liver, gall-bladder, pancreas, stomach, &c.
   - (*c*) Cirrhosis of the liver.
   - (*d*) Perihepatitis.
   - (*e*) Carcinoma of the liver.
   - (*f*) Obstruction of the inferior vena cava above the hepatic veins by thrombosis, or from pressure by a mediastinal tumour.
   - (*g*) Chronic lung disease, *e.g.*, emphysema and fibroid lung.
   - (*h*) Some cases of chronic valvular disease of the heart.
3. Leuchæmia.
4. Malaria, chronic (ague-cake spleen).
5. Splenic anæmia.
6. Hodgkin's disease.
7. Lardaceous disease.
8. Infarction (infective endocarditis).
9. Sarcoma (secondary).
10. Carcinoma (secondary).
11. Gumma.
12. Abscess.
13. Tuberculosis.
14. Hydatid.
15. Congenital syphilis.
16. Rickets.

It will not be necessary in connection with this particular case to discuss the symptoms, signs and characteristics of each individual enlargement mentioned above as there are very

few conditions which give rise to such an enormous enlargement as you see in the patient I have just presented to you. Enormous enlargement of the spleen, *e.g.*, an enlargement which extends well below the level of the umbilicus may occur in:—

Leuchæmia.
Ague cake.
Splenic anæmia.
Cirrhosis of the liver.
Hodgkin's disease.

It is not likely to be an ague cake spleen, as the patient has never been abroad, and has never suffered from malaria, or lived in a malarial district.

It is not likely to be cirrhosis of the liver, in spite of the alcoholic history, for it is most unusual in adults to find such an enlargement as you have seen in this case. I have never seen the spleen, in a case of cirrhosis of the liver in an adult, extend lower than the level of the umbilicus. In children, however, the spleen in this disease may be so enlarged that the lower end of it is jammed right into the pelvis so that you cannot feel its lower extremity. Some of you who are present here to-day no doubt remember seeing a little boy, who has often been admitted under Dr. Taylor, and whose spleen was thus enormously enlarged. He died last year, and at the necropsy the cause of the enlargement was found to be cirrhosis of the liver. During life the most prominent symptoms were jaundice, ascites, enlargement of the liver, and enormous enlargement of the spleen.

The only positive and conclusive way of determining the actual cause of the enlargement is by making a careful blood examination, and I shall now tell you how this should be conducted. You have already heard the result of the blood examination, and may have noticed that the red corpuscles were diminished in number, that the hæmoglobin was reduced, that the white blood corpuscles were much in excess, and that a very large proportion of these were cells (viz., myelocytes) which are not found in normal blood. A complete blood examination should consist of:—

1. A description of the naked-eye appearances of the blood.
2. An emuneration of the number of corpuscles (*a.* red; *b.* white).
3. An estimation of the percentage of colouring matter.
4. A microscopic examination of: *a.* fresh blood; *b.* fixed and stained films.
5. A determination of the specific gravity.
6. An estimation of the alkalinity.
7. A determination of the coagulation time.
8. A spectroscopic examination.

For practical clinical purposes the first four should be undertaken. The instruments used here are the Thoma Zeiss hæmocytometer, and the Von Fleischl's hæmoglobinometer, or Oliver's hæmoglobinometer.

As stated above, the blood examination showed:—

Red blood corpuscles, 1,900,000 to c.m.
White blood corpuscles, 256,000 to c.m.
Hæmoglobin, 40 per cent.

That is—a reduction in red blood corpuscles and hæmoglobin, and an enormous increase in the number of white corpuscles, the normal number to a c.m. being about 6,000 to 8,000. I have already mentioned to you that a mere leucocytosis, although it may be considerable, associated with a tumour in the left hypochondriac region, is not sufficient to enable you to diagnose leuchæmia with certainty. You must carefully examine thin films of blood which have been properly stained, and count up the different kinds of white corpuscles, and calculate in what percentage the various forms are present. You have been shown the technique of this examination in the excellent classes given by Mr. Pakes. It is so important that I shall again draw your attention to it.

The blood is obtained most readily and with the least inconvenience to the patient, from the lobule of the ear, which must be first carefully washed, then rubbed with lysol, and lastly with alcohol and ether. A puncture must then be made with a sterilized, sharp, broad-pointed needle. This one puncture should suffice for the use of the hæmocytometer and hæmoglobinometer and for the films.

The requisites for taking the films are:—

(1) Some long cover-glasses which have been boiled in a strong chromic acid solution, then washed in water, then in rectified spirits, and lastly in absolute alcohol. They should be kept in absolute alcohol.

(2) Some pieces of cigarette paper, about two by three-quarters of an inch.

(3) The fixing fluid.

(4) The stains.

The method of procedure is as follows:—

Take out singly as many cover-glasses as you require films, with a pair of pointed forceps, pass through the flame of a spirit lamp to ignite the alcohol. This leaves the cover-glass dry and free from grease. Pass the small end of one of the cigarette papers across the drop of blood so as to get a little blood on the under

surface of the paper close up to the edge, then quickly lay this edge of the paper, blood downwards, on to the cover-glass near one end, and draw it along to the other end; a very thin film of blood will be left on the cover-glass. In fixing and staining I have during the last year used the solution recommended by Jenner* in the *Lancet*, February, 1899, p. 370. It is a solution of eosin, methylene blue, and absolute alcohol. Place the cover-glass in a small open-mouth bottle containing the Jenner fluid, and allow it to remain there one minute; remove it and wash it a very little with distilled water, dry it with filter paper, and mount in Canada balsam.

I have found Jenner fluid act admirably. Its chief advantage is the ease with which it can be worked. The film can be fixed, stained and mounted ready for examination in five minutes, rendering the examination of blood films easy and practicable in the wards, out-patient department and consulting room. It not only gives good results in cases of leucocytosis and anæmia, but is very satisfactory for demonstrating the malaria parasite.

Another simple method is to fix the film by passing it four times through the flame of a Bunsen burner, then stain for thirty seconds in the following solution:—5 per cent. Grüblers yellow shade eosin, 75 per cent. alcohol. Pass through the flame again two or three times, and stain for about five seconds in a filtered aqueous solution of methylene blue. Wash in water, dry between sheets of filter paper, and mount in Canada balsam.

I have already mentioned to you the percentage number of the different kinds of blood corpuscles found in the blood of this patient. The nomenclature adopted by Cabot was used. A good deal of confusion exists on this point and is apt to be very misleading, as the same kind of white corpuscle appears under different names in the different text-books. The nomenclature which is now generally adopted and which in future I shall use is that recommended by Kanthack and Hardy, and is undoubtedly the most scientific and satisfactory. They describe the following kinds of white corpuscles in normal blood:—

(1) Lymphocytes, up to 30 per cent.
(2) Hyaline cells, 2 per cent.
(3) Coarsely granular oxyphile cells, 2·4 per cent.
(4) Finely granular oxyphile cells, 20 to 70 per cent.
(5) Coarsely granular basophile cells, absent in health.
(6) Finely granular basophile cells, 1 to 5 per cent.

The lymphocyte is an immature leucocyte, with very little protoplasm, and a large nucleus which stains deeply. It is not amœboid and not phagocytic. They are increased in number after food, and diminished after starvation. They resemble very closely the cells of lymphoid tissue. They are much increased in lymphatic leuchæmia, and are much diminished in spleno medullary leuchæmia.

The hyaline cell consists of an abundance of hyaline non-granular protoplasm, and a round or reniform nucleus which only stains lightly. It is amœboid and phagocytic.

The coarsely granular oxyphile.—The protoplasm contains large, highly refractile granules which stain deeply with acid aniline dyes. The nucleus is usually large and horseshoe in shape. It is amœboid but non-phagocytic.

The finely granular oxyphile is the most common form. The protoplasm contains small spherical granules which stain fully with acid dyes. The nucleus is polymorphic and it stains deeply. It is the same cell as Ehrlich's neutrophile cell, and it is the form which is mostly increased in simple leucocytosis.

The coarsely granular basophile.—The protoplasm contains large spherules which stain with basic dyes. The nucleus is usually round and stains fully. It is not usually found in the blood in health.

The finely granular basophile.—The cell substance is clear and contains a number of small spherules which stain with basic dyes. Their nucleus is usually trilobed. It is spherical in shape.

The following table which I have written on the blackboard is adopted from Adami's article on "Inflammation," in *Allbut's System of Medicine* (Vol. I.). I have added to it the nomenclature adopted by Cabot, and I think it may be useful to you:—

* Jenner's Stain.—"Equal parts of a 1·2 per cent. to 1·25 per cent. solution of Grübler's water soluble eosin, yellow shade, in distilled water and a 1 per cent. solution of Grübler's Medicinal Methylene Blue, also in distilled water, are mixed together in an open basin (not in a flask) and thoroughly stirred with a glass rod. The mixture may with advantage be left for twenty-four hours. It is next filtered and the residue is dried, either in the air or more quickly in an incubator or water oven. I have dried it at 55°C. without harm. When quite dry the residue is scraped off the filter paper and is powdered. It is then shaken up with distilled water and washed on a filter, where the washings should be of a thin, dirty, purplish colour. Finally, it is again dried and powdered and may be stored in suitable bottles. For use thoroughly shake up 0·5 gramme of the powder in 100 c.c. of pure methyl alcohol (G. Merck 'for analytical purposes') and then filter. The solution keeps well."

Kanthack & Hardy.	Ehrlich.	Cabot.	Metschnikoff.	Max Schultze.	Wharton Jones.
Lymphocyte	Lymphocyte	Small lymphocyte ...	Lymphocyte ...	Small round cell I. ...	Non-granular nucleated cells
Hyaline cells	—	Large lymphocyte ...	Macrophagocyte ...	Large round cell II. ...	—
Coarsely granular oxyphile	Eosinophilic cells ...	Eosinophiles	Eosinophile cells ...	Cells with coarsely granular protoplasm	Granule cells coarsely granular
Finely granular oxyphile	Neutrophile cells Amphophile cells ...	Polymorphonuclear neutrophiles	Microphagocyte ...	Cells with finely granular protoplasm	Granule cells finely granular
Coarsely granular basophile	Basophile cell with granulation	—	— ...	— ...	—
	Mastzellen	Mast cells	— ...	Cells with finely granular protoplasm	? Granule cells finely granular
Finely granular basophile	Basophile cell with granulation	—	— ...	— ...	—

In simple leucocytosis the finely granular oxyphile cells are chiefly increased, and this fact distinguishes it from leuchæmia.

There are two distinct forms of leuchæmia, viz:—

(1) Spleno medullary leuchæmia.
(2) Lymphatic leuchæmia.

Before the blood was subjected to such careful examinations, three varieties were described, viz:—

(1) Splenic
(2) Lymphatic } leuchæmia.
(3) Medullary

The patient you have seen to-day is suffering from spleno medullary leuchæmia, and his blood is very characteristic. The stained films show a very large number of cells which do not occur in normal blood at all. They are called myelocytes, because they are supposed to originate in the bone marrow. They are large spherical cells, each nearly filled by a large faintly stained nucleus immersed in oxyphile granules, and the nucleus is often in close contact with the cell wall for some considerable part of its extent. They are not amœboid. They are the largest cells found. Cabot gives the following measurements of the different kinds of leucocytes.

Average diameter of 100 myelocytes, 15·75 μ.

Average diameter of 100 polymorpho nuclear neutrophiles (*i.e.* finely granular oxyphiles, 13·50 μ.)

Average diameter of 100 large lymphocytes (hyaline cells) 13 μ.

Average diameter of 100 eosinophiles (coarsely granular) 12 μ.

Average diameter of 100 small lymphocytes oxyphile, 10 μ.

Average diameter of 100 red blood corpuscles, 7·5 μ.

The percentage of finely granular oxyphiles is usually diminished, and so also is the percentage of lymphocytes. Cabot gives as an average of 18 cases:—

Myelocytes, 37·7.
Eosinophiles, 4·4.
Polymorphonuclear neutrophiles, *i.e.* (finely granular oxyphiles), 49·2.
Lymphocytes, 7·6.

In addition, nucleated red blood corpuscles are also present in this disease and were found in the blood of the patient I have shown to you.

The above figures apply only, of course, to the percentages; in all cases the total number of white corpuscles in a cubic millimeter are increased in number.

Such a large total increase in the number of white corpuscles, with such a very high percentage of myelocytes is absolutely characteristic of spleno medullary leuchæmia, especially when associated with such an enormous enlargement of the spleen.

In leuchæmia lymphatica the

(1) Red blood corpuscles are diminished in number.

(2) The percentage of hæmoglobin is reduced.

(3) The white blood corpuscles are increased in number, but not to such an extent as they are in the spleno medullary variety.

(4) The percentage of lymphocytes is enormously increased, and the percentage of the other varieties much reduced.

e.g. The average in five cases of Cabot's.

Lymphocytes, 95.9 per cent.

Finely granular oxyphiles, 3·04 per cent.

Myelocytes, 0·7 per cent.

Eosinophiles, 0·36 per cent.

The examination of the blood and the discovery of such an extraordinary increase in the percentage of lymphocytes distinguish lymphatic leuchæmia with certainty from Hodgkin's disease and other conditions causing glandular enlargements or enlargement of the spleen.

In splenic anæmia the red blood corpuscles and the percentage of hæmoglobin are diminished and there is no leucocytosis.

I see my time is up, but I hope the fragmentary remarks I have made to-day will be of service to you and will stimulate you to make more elaborate blood examinations. I allude particularly to the making and staining of blood films.

Nursing News.

Matron's Office.

Miss Constance Arnold, (Head Nurse in John ward), who entered the Hospital in December, 1896, has been appointed Probationary Sister of Lazarus ward, to fill the vacancy caused by Sister Lazarus being transferred to Astley Cooper ward.

Probationer Gibson succeeds Nurse Vincent as Head Nurse in John ward, and Probationer G. Allen succeeds Nurse Arnold in the same ward.

Probationer Mallandaine has been appointed Head Nurse in Mary ward, and succeeds Nurse Suart, who has been here nearly five years, and has now received an appointment on the Army Nursing Reserve, at the Military Hospital, Caterham.

With the Army Medical Corps in South Africa.

(By Our Special Correspondent.)

Wynberg,
Tuesday, January 30th, 1900.

As our nursing staff here is reinforced from home, some of the earlier comers are being moved to the front; and it is good news indeed that two of the Army sisters who left here a fortnight ago are now working at Orange River, and that one leaves to-night to join two others at Modder River within a few miles of the Boer entrenchments. From the first it has seemed to the civilian mind quite feasible, and if feasible then most certainly desirable, that the nursing even in the Stationary hospitals up country should be directed by trained women nurses; and this is all the more the case, now that enteric and dysentery have made their appearance in some force. The only question was whether proper arrangements could be made for the accommodation of sisters near the front without impeding the military authorities, and this was a question for the medical staff to decide, a question which they have now decided in the affirmative. Indeed, the whole experience of the war will go far to show that military nursing should be, like civil nursing, largely left to women, and the orderlies set free to do the heavy work, and to help the surgeon in the less serious cases as dressers. The chief objection raised by the officers of the R.A.M.C. is that the orderlies must be trained for duty at the front; but if the men are properly trained, as they appear to be, in peace-time, they will be fit for work at the front in war; while the Stationary and General hospitals can be staffed by reservists who have already had their experience. A full nursing staff of a sister, two nurses and two orderlies to each hut of twenty-five beds could relieve the surgeons of most of the dieting, and a good deal of the minor dressings, which at present take up half their time; while the nursing could be carried out to perfection.

Until a few days ago every orderly in the place had to be on night duty every third night in addition to his daily work; that is, that on every third night he had to visit some half-dozen or a dozen wards, to which he was an absolute stranger, during two watches of two hours each, and get such sleep as he could in the "duty tent" in the intervals. In this way the orderlies had a poor time of it, and the patients were being attended by a different man every other hour, so that the orderlies never knew their cases. Now, by the arrival of a detachment of St. John's ambulance men, who can at least do the rougher work, it has been found possible to arrange for a proper system of night orderlies, who sleep in the daytime and of whom there are twelve, six to visit wards, three to be on duty with special cases, two to act as police for the camp and one to act in the duty-tent. Even so, and allowing for the fact that a large number of our patients here are convalescent, and require little

or no attention, the arrangements are insufficient for nursing from an ideal point of view, a fact that would become only too apparent if half the beds were to be filled with cases of enteric fever and dysentery, as may well happen before the war is over. But in this, as in all the cases where, to men used to work in the best civil hospitals in the United Kingdom, the arrangements would seem to fall short of the ideal, it must be borne in mind that, in the first place, these hospitals have been brought out 6,000 miles from home, and in the second that in former wars, in any country you please, except perhaps America, there has been no approach to a medical system in war half as complete as that now established in South Africa. The system is growing up, it has improved immensely on all previous efforts, and the authorities are doing their utmost to remedy such defects as remain. There is no stinting of instruments or apparatus of any kind. A fine stock has been brought out from home, and if anything further is wanted, and can be got from Messrs. Mayer & Meltzer's, a good shop in Cape Town, it is got sooner or later. The chief objection is the number of channels through which any request has to pass before it can be put into effect.

There was a mistaken notice recently in the *B.M.J.* stating that a pathologist had been appointed to this hospital. This is not so. Such an appointment had been mooted but was never passed, and the *B.M.J.* correspondent, an old Guy's man, by the way, only heard the suggestion, but took it to be an accomplished fact. It is a great pity that some such appointment should not have been made, as there would be plenty to do for a man in charge of medical cases only, if he were commissioned to do all post-mortem examinations (at present done by surgeons doing surgical work), and to make proper arrangements for staining for tubercle, trying Widal's reaction, and examining malarial blood and dysenteric stools, none of which things are being done properly, if at all. The further suggestion made was, that the officer detailed for such duty should act as an assistant registrar and ensure the proper and uniform reporting of all interesting cases, as at present there is no registrar, except in name, the "Registrar Secretary" being only a secretary; while the arrangement for reporting cases is far too vague to be of any scientific value. Indeed it would have been an excellent thing if the Colleges of Surgeons and Physicians had, with the consent of the Government, corporated to send a commission to investigate the whole subject of military medicine and surgery. Such commissioners could have seen all aspects of the work from the very front line to the Herbert and Netley hospitals at home, both in the Colony, in Natal, and later on in the republics; whereas men engaged in the actual executive of the hospitals can see only part of the subject and can hardly find leisure to do any systematic investigation. For instance, one can hardly over-estimate the value of a proper examination of the dead on the field of battle, however superficial it might necessarily be, and this most valuable field of information is at present wholly unexplored.

There have been two autopsies here this week; the first was a spinal case, the last of those that reached here from Magersfontein. He was shot through the back longitudinally in the median line from the seventh cervical to the sixth dorsal vertebra and had complete paraplegia. He developed extensive bed sores and died of septicæmia; and the spinal cord along the injured track was found to be completely pulped, without any collection of pus or blood in the membranes, such as might have justified a "laminectomy."

The other case was the first death in this hospital from dysentery, in which the case had completely resisted every kind of treatment and gradually sank from weakness. A few follicular ulcers were found in the large intestine and about the ileo-cæcal valve; there were scars of old healed and healing ulcers and the mucous membrane of the lower part of the bowel was considerably thickened and injected. There was no hepatic abscess or other complication.

One of the Boers is a case of considerable interest. He was bitten in the hand by a snake at Elands Laagte and his arm swelled up enormously in fifteen minutes. Free incisions were made and the hand was put up on an internal angular splint. On arrival here the wounds had all healed, but the tendons had become extensively contracted, and the "main en griffe" resisted all attempts at straightening it. Under chloroform to-day the tendons of the forearm were all found to be contracted, and it was found necessary to cut and splice all the tendons of the flexor profundus. The condition was a result of the arm being kept up six weeks in a splint in a cramped position.

The four consultants, Sir William Stokes, and Messrs. Watson Cheyne, Rendal Franks and Cheatle, did not go on to Durban at once, as I said in my last letter; as they came in to lunch at our mess last Thursday, together with Messrs. Wallace (St. Thomas's) and Calverley (St. Bart.'s) of the Portland hospital. But it is said that they are to be scattered very shortly, one to Natal, one to East London, and one to De Aar.

Mr. J. N. Gardiner is at present with No. 3 at Rondebosch; Mr. S. Whicher has gone to Natal.

Mr. V. E. Collins came on here to dine with me last night. He is acting "permanently for the present" under Mr. Charles Anderson, at the Somerset Hospital. The Somerset is the only civil hospital of note in these parts, and Mr. Anderson, as resident surgeon, has much of the best work to do. Mr. Collins had many notable tales to tell. Amongst others was one of a farmer from near Aliwal North, who was on board the ss. German on her way down from the coast ports to Cape Town, just before Mr. Collins left the ship early in December. The farmer knew the country and people round Stormberg well, and said our military authorities had got hold of the worst lot of guides imaginable, and he would not be surprised if there were trouble accordingly. The next day the German reached Cape Town and they received the news of General Gatacre's reverse.

The war here drags on wearily, as we get no news, and are continually fabricating rumours. Ladysmith has been relieved several times, and to-night it is the turn for Mafeking, together with a capture of all the Boers at Colesberg. We look accordingly for reinforcements from Guy's, and above all for the Yeomanry.

Tuesday, February 6th, 1900.

A number of the "Hospital" has arrived with an extract from a former letter of this series in the Guy's Hospital Gazette about nursing. It has created almost a sensation in the nursing world here; the army sisters resenting what they consider as an implied insult, while I believe the reserve sisters, who come straight from civil hospitals, are unanimous in their approval of the criticism. No blame is attached to the army nursing sisters, who fill a very difficult and ill-defined position with commendable patience and courage. But there is no need for the present limitations of their sphere of work in a general hospital; and the authorities have now increased the staff of seven nurses here to twenty; and in addition, sent several nurses to Modder River and Orange River, thereby proving their sense of the wider scope which is open to proper nursing. The hospital as a result runs infinitely more smoothly; especially seeing that the recruits are staff-nurses of the highest quality from London hospitals, and I will vouch for the fact that the treatment is in consequence more thorough, the wards more comfortable and home-like, and the patients distinctly happier. I could enlarge upon this topic to any extent. But it would not interest your readers, it might be impolitic, and it could not, nothing could, bring about in the middle of the war the complete change of system that most of us agree to be necessary in future. Nor are these remarks meant as any slight upon the orderlies. The orderlies are well-trained in their duties; they are for the most part keen and willing, and they are delightfully kind and gentle in their dealings with really serious cases. But they are drawn from the same classes as the private soldier, and they are men, not women.

The hospital has for some time been emptying, and this week the general hospitals were all three ordered to send out as many cases as possible, presumably in the expectation of a big move from "this side," as they say in the Cape. We have again, however, been temporarily filled up by a batch of 185 from Natal, convalescents, of course, no acute cases, whether surgical or medical, being able to stand the journey, or rather the frequent shifting involved. One of my wards has fortunately been filled entirely with cases of the subacute dysentery which accounts for a large proportion of the sick in this campaign. These cases begin as a rule with an acute diarrhœa, the maximum number of stools (10 to 30 in the day) being reached on the 3rd to 7th day of illness, frequently the day on which the patient reports himself sick. The stools are usually small, slimy and streaked with blood, there is considerable tenesmus at the time, and griping pains of greater or less severity in the intervals. The pains are constantly increased by taking solid food, and especially meat. The temperature is often raised to 101° or 102° for the first day or two in hospital, and then falls to normal. Whether it is causally connected with the tropical dysentery it is difficult to say, especially as we have not yet made any systematic search for amœbæ coli. But clinically there is no line to be drawn between the slight attack of the above nature and the true tropical dysentery leading to hepatic abscess. In No. 1 we have not yet had a tropical abscess; but in No. 2 they were opening a tropical abscess only two days ago. We have had one death from dysentery in about the third week, the colon showing follicular ulcers, signs of cicatricially-healed ulcers, and thickening of the mucous membrane, but no hepatic abscess.

As to the treatment of dysentery, there is only one thing definite and that is the supreme importance of rest and dieting. When a patient is brought into hospital and left alone, so long as he stays in bed and has only a farinaceous and milk diet, the greater part of his symptoms in nine cases out of ten clear up within a fortnight or less. But even so there is generally some slight symptom which persists, such, for instance, as slight pain in the bowels only on walking about, which prevents the man being sent back to duty, consequently some form of treatment becomes necessary; and at present it appears as if these cases are best treated with frequent doses of Bismuth and Opium; Bismuthi Subnit. gr. xv., and Liq. Opii. Sed. ɱv. every two hours from 6 a.m. to 8 p.m. is my own order. But at present one can only say that this seems to hit off more cases than any other form of treatment. In one series of six cases I gave Ipecacuanha gr. xxx. by the mouth, with the usual precautions against sickness, twice in a day; and the result on the whole was certainly good. But even repeated administration failed to completely cure in most of the cases. Ipecacuanha per rectum of course ensures its being retained, but does not assure its reaching all the affected surface.

As to Mag. Sulph., we have tried it every way. The "white mixture" of this hospital actually contains ʒiv. to ʒi. and does not appear to be too much for domestic use. I have given it three times daily for two days or longer; and as a rule it only increases the number of stools from six or eight to eight or ten. But as a rule it is usually given here in doses of ʒss. or ʒi. every two hours during the day. A similar, and in some cases more useful form of this treatment—washing out the bowel—is that by Castor Oil and Opium; and I have tried this method followed by Ipecacuanha, with some, but not with complete, success.

Time prevents any further writing, so I must close.

Papers by Guy's Men.

A Clinical Lecture on Mental Dissolution. By G. H. Savage, M.D., F.R.C.P. Lond.—*Lancet*, 10th February.

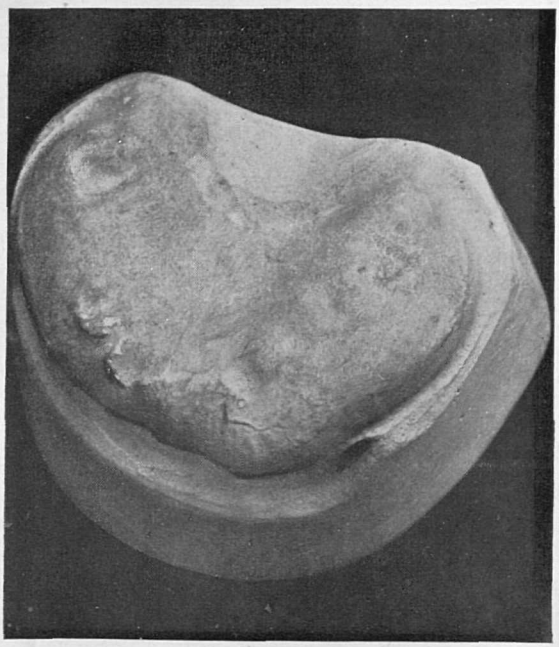

FIG. I. $\frac{2}{3}$ NATURAL SIZE.

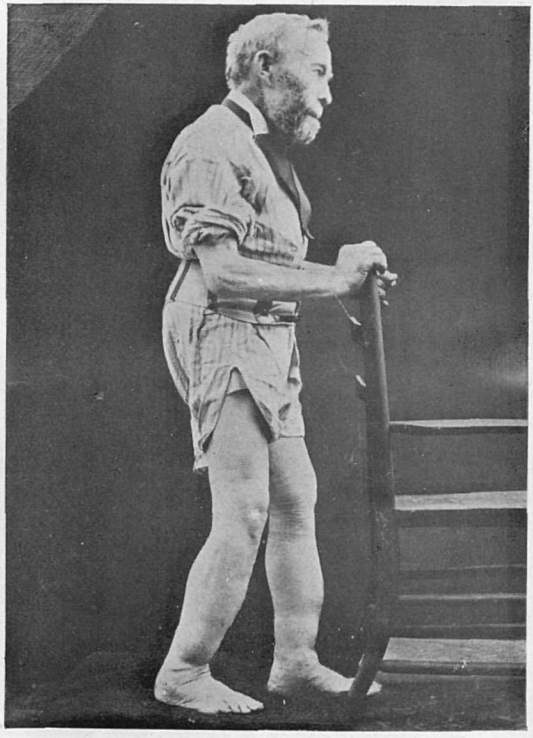

FIG. II.

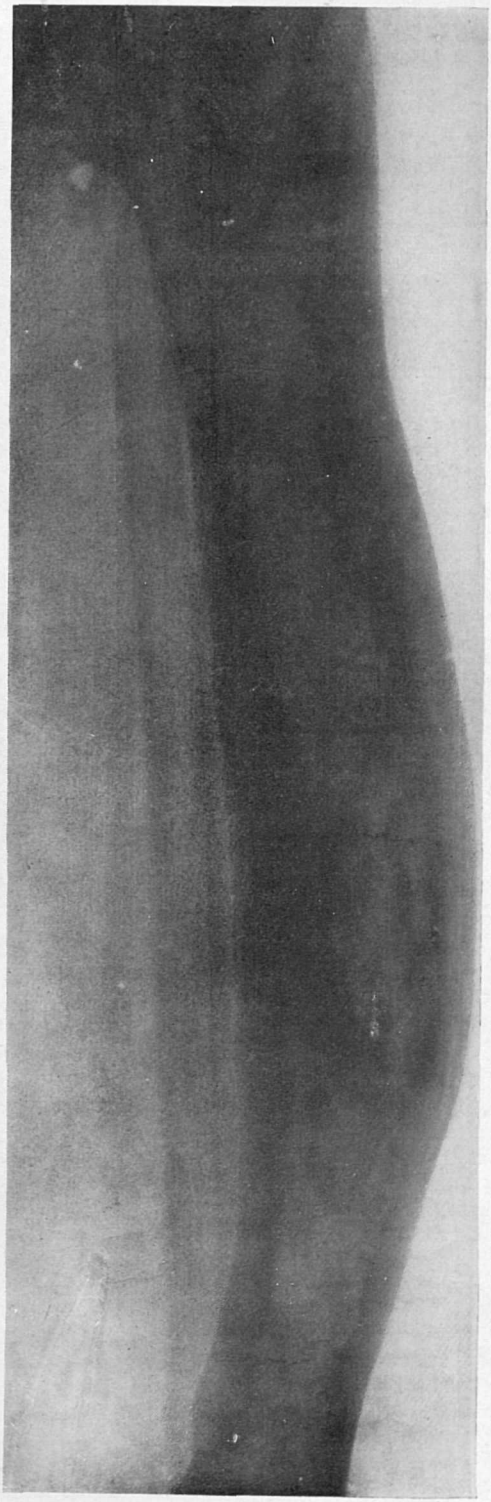

FIG. III.

OSTEITIS DEFORMANS.—By E. COUCHMAN.

Passim.

We have received a letter from Mr. Symonds calling our attention to the efforts which are being made to provide the Royal Army Medical Corps with "comforts." It is hardly possible nowadays to pick up a morning paper without finding an appeal for, or a reference to, a fund for the provisional of creature comforts for troops in the field. Hitherto, speaking generally, the branch of the service to which we are most closely allied has been left in the cold. But now a powerful committee has appealed to the medical public, and the *Lancet* and *British Medical Journal*, have already opened subscription lists. For our part, we shall be only too pleased to help in whatever way we can. The Librarian, himself an old army man, has offered to receive subscriptions from present Guy's men; the Gazette will be pleased to receive and to acknowledge in its columns donations from men who are no longer at the hospital. Finally, there is a third alternative. Subscriptions may be sent directly to the honorary treasurer of the fund, Mrs. C. J. Symonds, 58, Portland Place, W. In order that the appeal may be responded to as generally as possible, it is suggested that the Librarian's fund should be limited to shillings, while our Gazette fund, to fall into line with those of the *Lancet* and *British Medical Journal*, is fixed at half-a-crown. We hope that the excellence of the object will prompt a ready response to this appeal.

From "the other end" has come a suggestion which is ingenious if not strictly practical. As is generally known, the Dissecting-room is in the charge of three "Demonstrators of Anatomy" and two "Student Demonstrators," and the general work of the whole room is under the supervision of a demonstrator from each of the two classes. It is now proposed that a third Student-Demonstrator should be appointed in order that each senior demonstrator may have his own junior. The next step would provide for the apportioning of the room into three divisions, each under the direction of a pair of demonstrators. And then finally comes the inevitable result, and the object at which this proposal aims. A feeling of rivalry would be engendered; each class would consciously or unconsciously, seek to outshine its fellow, with, it is believed, an improvement in the examination results. A very obvious objection to this system is that it fails to provide for relief. Either the demonstrators would be on duty always, or else a division would be left masterless when the hour of a tuitional class happened to coincide with the duty time of the demonstrator. Also, there are such things as faction fights.

The Debating Society is really in a very flourishing condition. The question before the House on the 24th ult., on the advisability of introducing some form of conscription provoked one of the heartiest debates we have ever had the pleasure to attend. Both proposer and opposer had acquired a good grip of the essentials of the subject, and, with one or two exceptions, the speakers who followed shewed little tendency to wander into the bye-paths of irrelevancy. There was, as is only to be expected when subjects of this nature are treated by lay speakers, a good deal of bold "bluffing," and plenty of amusement when the incautious bluffer was forced into an untenable position. On the whole, however, the House treated the motion with due solemnity, and thrashed out each point with commendable earnestness. Previous to the question of the evening, "private business" of a somewhat personal character was transacted. To many it might appear that this "private business" is mere puerile trifling; it is a curious fact, however, and one that is not altogether surprising, that these little passages of arms between members tend to clear the air for the more serious business of the evening; and for this reason alone "private business" has its value.

The Committee of the Debating Society has decided on Saturday, March the 24th, as the date of its annual ladies' night. The speakers on this occasion have not yet been chosen, nor has the subject of the debate been officially announced. It is rumoured, however, that the great drink question, beloved of debating societies, is to be dragged from its modest seclusion and set up as the Aunt Sally of our verbal missiles. It is generally unnecessary to ask for an audience on these occasions. At the ladies' night last year it was a physical impossibility to enter the room half an hour after the debate had started. This year, the Committee is seeking to provide much more accommodation than was possible last year, and we expect that everybody will be able to find a seat and his proper volume of breathable air.

We have had given us a very beautiful little phamplet issued by the British Union for Abolition of Vivisection, and entitled "An Appeal addressed to the Poor Law Guardians of England." The special subject on which it offers enlightenment is that of inoculation with antitoxin serums. With reference to diphtheritic antitoxin the following passage occurs (the italics are our own): "Four years ago, when the medical officers of a district in the East-end wished to purchase this antitoxin, only three of the guardians voted against it, but quite recently seven guardians on that same Board strongly opposed authorising the purchase. *This seems to indicate a growing distrust of the treatment.*" The scientific value of the opinion of an East-end Board of Guardians is not stated. The writer then calls attention to "a noteworthy fact brought out by the statistics quoted by Professor W. R. Smith. . . This startling fact is that London, where the serum is much more generally used than elsewhere, has an unaccountably far higher death rate from diphtheria than the country at large." Then after this little bit of word juggling, an entirely novel objection to serums is introduced. "In the official report on the plague in Calcutta there is a ghastly story of making cultures from a plague case of a woman of notoriously infamous character in a wretched native hut." Just fancy! an immoral serum!

The next musical entertainment at the hospital will take the form of a smoking concert, and will be held in the club rooms on Saturday, March 10th. It is a healthy sign to see the revived interest which is being taken in this class of entertainment; after the postponements *sine die* of the last few years, we began to look upon smokers as doomed to failure before their inception. This concert is the second of a new era, and if it proves as successful as that given earlier in the season, there will be little room for improvement. Men of musical talent, who are willing to help, should apply to any resident for further particulars.

Among our usual batch of complaints is one which might easily be remedied, to the obvious benefit of the student. The grievance is, that whereas due notice is given of operations performed by the surgeons on the official operating days, yet there is nothing by which a man can ascertain what obstetric operations are arranged for the obstetric physicians. The colonnade has already received one addition to its historic collection of indicators in the clinical lecture notice board. If a small board with notices of obstetric operations were likewise to be exhibited, men up for their finals in Midwifery would be sure of that practical acquaintance with surgical methods which is worth such indefinite quantities of theory. The necessity is the greater, in that the journey up to Queen ward is of great magnitude, and not to be lightly undertaken on the off chance of seeing the operation that you desire. Of course we shall change all that when we get the electric light and electric lifts and things.

On Wednesday last the Association team beat Eastbourne by 5 goals to 1. Eastbourne have always been among our most formidable opponents, and the fact that we have not beaten them for five years, goes to prove that they generally give a good account of themselves. It is a pity the team did not play in its usual form against Bart.'s, in the Cup-tie, otherwise the result should have been reversed. On the day's play, however, Bart.'s were perhaps a trifle in front of us, but the season's results, which are better than for some years past, raised hopes in our hearts that more luck would back us in the Cup-ties. We have no complaint against any individual man, but each was just a little below his usual form, and to that we think our defeat was due. On Wednesday, though there were grave fears of defeat, each man played for all he was worth, and so our old opponents Eastbourne were more severely defeated than on any previous occasion, at any rate within the ken of present Guy's men.

Once more we shall miss the cheerful presence of the Rugby Cup, which has for the past two seasons graced the walls of the Club Smoking-room. Just as we were beginning to get used to it, and were able to point it out to our lady visitors through the opposite window as a mere trifling ornament, we have let it slip from our grasp, allowed it to recede to the other side of the river. If, however, the same teams met again under the same conditions, we feel that Guy's would have pulled the game off twice out of three attempts; at the same time, we have no desire to depreciate the success of our opponents; they played a great game, their defence was never broken, and they smartly availed themselves of the one opportunity afforded them. Our men pressed gallantly; they were in their opponents' quarters for two-thirds of the game, but they lacked the dash and finish necessary to convert pressure into possession, moreover,

fortune smiled not upon them. We cannot help thinking that as holders our men have shown less keenness than as hankerers after the cup; there has not been the same determination to get fit, the same combination as was shown when we beat St. Thomas's two years ago. Perhaps the war has with some over-shadowed the winning of cup-ties; we commiserate with Mullins on failing to hold the cup; we congratulate him on the relief of Ladysmith.

We were pleased to see the president of the football clubs following the game with keen interest, and also to note the presence of many members of all departments of the hospital. It is a noticeable feature of the cup-ties in which we are interested that there is an absence of the old horseplay and senseless braying which used rather to distract than encourage the players; true, there was sound enough, but it was well timed and not discordant. Our men took their defeat well; they appreciated the efforts of our own, and the sportsmanlike behaviour of the other side.

Of the players, Harrison did all that was required of him, and he cannot be blamed for the single score recorded against us; Pye-Smith, though he made mistakes, tackled much better than usual, and played throughout with great dash; O'Brien kicked well and tried to feed the wings, who unfortunately did not get the chances they should, as the ball invariably came away too slow from the scrimmage. For this we think Jackson and Louisson less to blame than the back row of the scrum. Both halves were rather slow in securing the ball and passing, being much hampered by the opposing pair, of whom Soper was particularly smart. The forwards showed a want of judgment which we did not expect of them; they did not secure the ball either on the line out or in the pack as often as their opponents, and when they did so it hung fire in the back ranks in a way that prevented our halves from passing out. All were good in tackling and the loose rushes, but we expected more from our fast cruisers, Thomas and Manson, and Cutler's absence was much felt. Mullins, hampered by a damaged ankle, played his usual good game, and was well supported in the scrum by Trail, Wall, Trubshaw, and the rest.

The Annual General Meeting of the Guy's Hospital Rifle Association will be held on Thursday, March 8th, at 12.45 p.m. in the Surgical Class-room. Mr. Dunn will be in the chair, and it is to be hoped that a large number of men will turn up and shew that the interest in this useful sport has not died out. The business to be transacted will be almost entirely that of the election of officers. There are plenty of vacancies and much need for fresh blood. We held the Hospital Cup in '98, and with any luck we ought to get it again this year. We shall want something to fill the vacancy caused by the loss of the Footer Cup; the Shooting Vase will do as a temporary measure.

The proposal to form a Volunteer Corps at this hospital has been very energetically taken up in the Dissecting-room. A goodly number of names has been received, and it is now proposed to hold a meeting at which the matter can be thoroughly discussed. It would be premature to mention any ideas which have been projected on the nature of the corps and its scope. We hope, however, that the movers in this matter will give us the opportunity of publishing the date of the meeting, so that every man who is interested in Volunteering may attend. In the meanwhile discussion should be suspended, for there is always a danger of wrecking a scheme of this nature by rash promises and insufficient knowledge.

We have been asked to state that Canon Gore will deliver an address to Hospital men in the Chapel next Monday at 5 p.m. The address might, perhaps, be more aptly described as a short lecture of about half-an-hour's duration, and will form one of the course of "Religio Medici" lectures. By the way, we hope in our next issue to publish a short report of the lecture delivered by Mr. Russell in this series; it will be impossible, however, to reproduce the chief charm of the address, which lay in the personality and manner of the speaker. Next issue, too, we are publishing a series of photographs which have been forwarded by our correspondent in South Africa. They are of especial interest in connection with the letters which have appeared in these columns, and of which they form an essential and integral part.

Our heartiest congratulations to Messrs. Fox and Denny, who have been placed first and eleventh respectively in the examination for surgeonships in the Royal Navy. And our

congratulations to the Navy also on securing two such capable men. We must also offer our congratulations to Mr. Tilbury Brown, who has been nominated by the Medical Council to a commission in the R.A.M.C.

MISS NOTT BOWER, our late Matron, has written us, to thank through these columns the Nurses of the "Institution" for the very handsome present that they have sent her. "I much appreciate the kind thoughts of the Nurses in sending me such a lovely present, and more so since I have been able to see so little of the private nurses individually for so long now, and have only been able to work for them and show my interest in them, as a manager of the Institution, though it is needless to say that they have always had a warm corner in my heart. Please give my heartiest thanks to each and all of them."

THE combined Choral Societies gave their concert last Tuesday. On another page will be found a criticism of the performance, so that it is unnecessary to do more than briefly refer to the fact here. There was not a very great attendance of either nurses or students; the audience was chiefly composed of the friends of individual members of the choirs. Doubtless the awful condition of the roads, the howling winds and driving rains, prevented many from coming who would have been present under more favourable circumstances. However, on the whole, the evening was enjoyable and apparently sufficient recompense for the discomforts of travelling.

Chapel News.

A LIST of the Lent services in the Chapel has been printed and will be found in the Chapel Porch.

The special feature of the services this year is the coming of the Rev. Canons Gore and Newbolt to lecture to the men of the Hospital. Canon Gore's lecture is on Monday next (March 5th) at 5 p.m., Canon Newbolt's on March 26th at the same hour.

The Instructions on Tuesday evenings at 8.15 will be given by the Rev. A. W. Bedford, Vicar of All Hallows, East India Dock, and the Rev. J. H. Browne, Vicar of St. Andrews, Stockwell, and Chaplain of the Fever Hospital. Mr. Bedford will take the first two, and Mr. Browne the last three.

Guy's Hospital Dental Society.

(*Concluded from p. 91.*)

It is important to remember that missing teeth may lie quietly in a follicular odontone for years and not cause any trouble, beyond their absence from duty, until the patient has reached adult life. I remember reading of a case some years ago where a dentist had the unusual experience of extracting two bicuspids and a canine from the place where the canine should have been, in a period of a few months, from a young woman over twenty years old. Next I propose to discuss very briefly swellings found connected with the salivary glands. Calculi are easily diagnosed because of their hardness, and being unattached to bone, they can be felt to be lying loosely in soft tissue, also the duct in which they lie would be blocked, no saliva being able to pass. In this way they can be distinguished from a ranula, where the opening of Wharton's duct can be shown to be free from the ranula. A ranula is a cyst of some sort found under the tongue, not connected with Wharton's duct, containing a glairy fluid. It is not yet decided whether it is mucous or salivary, or a retention cyst. As a soft fluctuating cyst it can be easily distinguished from a calculus. If felt with a probe a calculus has a hard earthy feeling.

There is a specimen here (425 Path. M.) of salivary calculus in the submaxillary gland: "The patient was under Mr. Davies-Colley, in 1890, for swelling beneath the jaw on the right side, and a hard mass which could be felt on the floor of the mouth at the situation of the opening of Wharton's duct. Six months before a calculus had been removed from the same duct. At the second operation the submaxillary gland was excised. The specimen shows part of the gland, with its duct dilated, in which a calculus is lodged. The smaller calculi at the bottom of the glass are also from the same gland."

When we get outside the mouth, in dealing with the parotid gland, there is a greater number of tumours to be thought of. A swelling over the region of the parotid gland may be—not connected with the gland—a lipoma or fatty tumour, myoma, or muscular tumour, sebaceous cyst; or connected with the gland—an abscess, fibroma, myxoma, chondroma, sarcoma, or carcinoma. Mumps is, of course, also connected with the parotid gland. The tumour can be eliminated from the former class by defining its connections, but if it is found to be attached to some tissue outside the gland a differential diagnosis between those tumours must be made. If, however, the tumour is found to be connected with the gland it is most likely to be a fibro-cartilaginous tumour, as that is the most common one; cysts are very rare. It is often impossible to tell what a tumour in this region is, the main point is to decide whether it is innocent or malignant, and to remove it accordingly.

There is a fibro-cartilaginous tumour here (433 Path. M.) cut from a patient, aged 29, by Mr. Birkett. It had

been growing for twelve years, which is a point to notice.

Next we come to tumours found connected with the gums. First we make sure that the swelling does arise from the gums and is not an alveolar abscess, which may easily be ascertained by looking at it and feeling it.

A polypus of the gum is a local hypertrophy caused by irritation, generally of a cavity in a tooth, rough filling, denture or root. It rises in the gum itself, not the periosteum. It may be distinguished from polypus of the pulp by noticing that it is joined *outside* the tooth to the gum. It is generally extremely painful. I can speak from experience on this matter having had one between my right lower central and lateral. It made talking almost impossible for several days. If allowed to grow a polypus of the gum may degenerate into a fibrous epulis by reaching the periosteum.

Fibrous epulis is caused by irritation, often from a root, and grows from the fibrous tissue of the periodontal membrane. It is generally found between the teeth. Walsham describes it as a "hard, fleshy, circumscribed, smooth, or slightly lobulated elastic tumour, covered by mucous membrane; it has a tendency to ulcerate and causes the teeth affected to loosen and fall out." It can easily be recognised from its locality, attachments and appearance. If completely removed it does not recur, but if any is left it grows again.

General hypertrophy of the gums I shall not touch on as it is fortunately rare, but I am delighted that the deficiency has been so well made up to night by Mr. Hopson.

Here we have a fibrous epulis (352 D) connected with the periosteum of the left upper central or lateral of a girl, aged 20. There was a history of a blow having been received six years previously, but the present tumour had only appeared six months before; it had been gradually increasing during that time. Mr. Symonds cut it out with the bone involved, which he also gouged out. It healed well and showed no signs of recurrence.

Here is a specimen of another fibrous epulis (439 Path. M) connected with a lateral incisor. The patient was a man of 31; he had had the growth twelve months; the gum was thickened by chronic irritation produced by a plate for artificial teeth.

The thickening of gums and mucous membrane produced through irritation of dentures will disapper in time if the cause is removed, and a more healthy state induced by restoring normal circulation by friction with, say, a tooth brush.

Here is another specimen of fibrous epulis (440 Path. M) by the side of a root of a molar. The patient was admitted under Mr. Jacobson, in 1893, with a tumour on the side of the molars in the upper jaw; it had been growing for eighteen months. The growth was removed, and the patient discharged cured a week later.

It seems to me, gentlemen, that we should learn from these cases and other similar ones to be seen in the museums, the necessity of removing useless ragged roots. If it be decided for any reason that a root is to be left in the mouth uncrowned, something should be done to render it innocuous—filling, if possible. There seems to be a feeling among a few that the fillings and crowns in a mouth are all important, and to neglect the removal of any useless roots. I should like to suggest that although the roots *may* be perfectly healthy now, there is no guarantee of their remaining so, for if the physical condition of the patient is lowered by sickness or any prolonged strain, these roots will then, in all probability, discharge pus to some extent, if nothing worse happens; and then the fact that fibrous epulis has been caused many times by broken down roots should be borne in mind.

Myeloid sarcoma occasionally occurs in gums, and may be distinguished by its rapid growth, purplish red colour, and soft spongy nature; it shows great tendency to bleed. In removing it, the bone adjacent must be taken as well, or the growth will recur.

There is one pathological condition of the tongue that I must mention. Epithelioma very rarely occurs under the age of forty. It is generally begun as an irritable ulcer, through irritation of a rough tooth, pipe-stem, or rough edge on an artificial denture. Any sore noticed on the tongue of a patient should be carefully examined. Probably it would be, if of short existence, a simple ulcer caused by disturbance of digestion. But if it exists more than a few days a source of irritation should be sought for and removed, and the patient warned against neglecting sores on the tongue. After the history of the sore, the special points for notice are the edges (if an ulcer) and the appearance of the mucous membrane round it. The edges of an epitheliomatous ulcer get hard and turn outwards. They generally begin as a horny growth, and afterwards, if the irritation continue, break down into an ulcer. This teaches us the importance of having everything in the mouth perfectly smooth; rough fillings, broken teeth, and sharp points in dentures are to be most carefully avoided.

We have here (461 Path. M.) a specimen of growth which only existed five weeks, showing the importance of recognising early and dealing promptly with these tumours. This specimen is half a tongue; it is divided to show a white growth dipping down into the muscle. It was cut out by Mr. Howse in 1888. The patient made a good recovery.

Regarding the antrum, I shall say very little, as we are now having the privilege of lectures on the subject. I would just remind you that the difference between innocent and malignant growths in this region may be still further noticed in their action on the dental arch, innocent growths moving it slowly and evenly out of place, while malignant ones force it quickly and scatter the teeth in irregular directions.

Also I have here a model of the upper jaw of a patient who came under my care some time ago. She gave me this history. The four upper front teeth were cut down to the gum level, and the roots left in, artificial teeth were then put over them. Soon after this great swelling occurred in the face and palate. She described the swelling in the face as reaching the eyes with great

prominence, and the abscess in the palate as hanging down to her tongue, filling up the vault of the palate. After about a week the abscess burst into the palate and nearly choked her. The swelling soon disappeared and healed up, but left the swelling in the palate which you see on this model, and though that is nine years ago it remains to-day. It will give way to some extent on being pressed, but it is not really soft. I imagine it contains cystic walls and fibrous tissue.

In conclusion, I will just mention a few special points about tumours of the lower jaw. It must be remembered that cysts between the two plates of the jaw will seriously thin it out and so weaken it if left to develop. It will be helpful to remember also that osteomata have a preference for the angle of the jaw, the inner side of the canine region, and the mental foramina. In thinking of osteomata a possible obstacle might be caused by a previous fracture having made a callus that might be mistaken for an osteoma. The history will of course clear this up.

Now, gentlemen, I wish to express my thanks to Mr. Payne for letting me have these models from our Dental Museum, and to Dr. Shaw for the use of these specimens from the Pathological Museum. Also to you all for the encouragement of your presence and attention.

In conclusion, Mr. Baker thanked Mr. Bennett for his paper, and gave a short account of two cases which it recalled, and having announced that the next meeting would be devoted to the discussion of Clinical cases, the proceedings terminated.

A MEETING of the above Society was held on Tuesday, February 15th, Mr. Payne occupying the chair in the absence of the President. The minutes of the last meeting having been accepted, "casual communications" were presented by Messrs. Dowsett and Wartski, and the consideration of the "clinical" cases was then proceeded with. The first, shown by the Secretary, was one of "Endosteal Sarcoma of the Lower Jaw." The patient had been operated upon in March, 1895, and aided by her ward report of the time, furnished a very complete example of such a case. A discussion arose as to whether the patient's glands, which the report mentioned as being enlarged, were the seat of secondary growth or merely inflamed; the history of the case proved the latter to be correct, as all enlargement had subsided since the operation without further treatment. The second, a case of "Osteitis Deformans," shown by Mr. Couchman, proved of great interest. The patient, a gardener, aged 74, had great enlargement of his upper jaw (see Fig. 1, taken six months ago and representing jaw to be smaller than it now is) and well-marked deformity of his tibiæ (see Fig. 2), also the cranium was enlarged and thickened, the cervical vertebræ were inclined forwards, causing the head to protrude, and the spine was bent convexly to the right, throwing the head and shoulders to the left (see Fig. 3) His gait was tottering and unsteady, support being required; he stooped considerably, lent well to the left side, and carried his head projected in front of him in a manner characteristic of "Osteitis Deformans." His face showed signs of suffering, and he complained of neuralgic pain in his head which was worse at night, noises in his ears, considerable pain in and just above his knees, and also of weakness of his back. The patient connected his illness with an accident that had befallen him twenty-five years ago, when a large piece of timber fell on his face, knocking out several of his teeth, but not fracturing any bones to his knowledge, as it was shortly after this that he noticed alteration in his cranial bones, which had been increasing in size steadily since; he had not noticed his tibiæ till about seven years ago. The great interest attached to the case was owing to the superior maxilla, which bone usually escapes deformity in this disease; the mandible, the hands and the feet were quite normal. The third case, "Excision of both Condyles of the Mandible," was shown by Mr. Dowsett; the operation had become necessary by the patient allowing her jaw to become fixed in a dislocated position produced in an epileptic fit. A fourth case, shown by Mr. Payne, was one of "Alveolar Necrosis of both Upper and Lower Jaws." Some interest was attached to this owing to the cause being idiopathic. Two other cases were mentioned, "Osteo-Arthritis of the Temporo-Maxillary Articulation." Unfortunately this patient wrote saying she was too ill to appear; and another of "Unilateral Facial Neuralgia with stiffness and pain in the Temporo-Maxillary Articulation of the same side, combined with a past history of Mumps, Rheumatism and Gout." The discussions were well sustained, and the chairman having announced the next meeting, proceedings terminated shortly before 7 p.m.

Guy's Hospital Officers' and Servants' Dinner.

A DISTINCT triumph was scored at this dinner, which was held at the Bridge House Hotel on Feb. 19th. Apart from the goodly number of diners,—no mean factor of success in such undertakings,—good speeches and an excellent musical programme combined to make the evening most enjoyable. Indisposition prevented Mr. Cosmo Bonsor from taking the chair; accordingly, his secretary, Mr. Williams, whose forty years' service give him the title of the oldest official of Guy's Hospital, sat at the head of the table. Among his supporters were noticed Dr. Perry, Dr. Fawcett, the Rev. B. S. Sladen, the Rev. A. Gregory, Messrs. Wood, Kirkland, Wells, Reaside, Millar, and the Editor of the Hospital GAZETTE.

After the usual patriotic toasts proposed by the Chairman,

Mr. REASIDE proposed "The Navy, Army, and Auxiliary Forces." In a stirring, earnest, speech, Mr. Reaside spoke of the splendid work of the soldiers and sailors of the empire, and after expressing his unshaken faith in the capacity of our soldiers, appealed to his auditors for a searching enquiry into war office methods.

Mr. Mills, the librarian, replied in an excellent little speech, in which anecdotes of personal experiences predominated.

In proposing the toast of "Guy's Hospital,"

Dr. Perry made undoubtedly the speech of the evening. There was just a tinge of sadness, but occasionally relieved by a flash of quiet humour, which made his whole delivery singularly graceful and poetic. One realized the magnitude and awe with which Thomas Guy, bookseller, had enshrouded his name.

Mr. Marson, our youngest Governor, replied in a neat speech, which went to the hearts of his audience at once. He expressed the feelings of "newness" which his situation involved, but declared that he had already made many friends that night, and before the next dinner he should have made a great many more.

Mr. Croucher proposed the health of the two Schools in a speech which occasionally reflected the scarlet coat of his brother. Indeed, the prevailing tones of every speech that night were Imperialism and Patriotism, After several graceful little allusions to gentlemen present, and amusing anecdotes "from the office," Mr. Croucher gave place to

Dr. Fawcett who replied in a short speech which set the table laughing heartily. His self-deprecating allusions to the corporate weight of the Medical School Officials when compared with the Hospital Authorities were distinctly funny.

The last toast of the evening, "The Visitors," was proposed in a short but hearty speech by Mr. Telling, and briefly replied to by Mr. Hodgson.

During the evening the following gentlemen provided an interesting musical programme:—

Messrs. Parrott, Laughton, Field, Rowlett, Soper, Pitman, Gough, Mason, Lyons, Robinson, and Hedges.

Finally, at the earnest desire of the whole company, Mr. Victor Andreoletti trolled forth in his rich tenor voice "The Three Jolly Smiths," with chorus. "Auld Lang Syne" brought a most enjoyable evening to a close.

Nurses' Choral Society and Students' Glee Club Concert.

On Tuesday, February 27th, the Nurses' Choral Society and the Students' Glee Club combined forces once more to give their fourth annual concert. The concert was well attended, but the room was not packed as we have seen it on previous occasions. Probably the inclement weather was largely responsible for this. To the same cause, undoubtedly is to be ascribed the fact that of the many members of the staff we are accustomed to see grace such an occasion with their presence, we could only discern one among the audience. The weather is responsible for a great deal, and there is a further charge to be laid to its doors: some of the voices betrayed the marks of its inclemency by a huskiness and a straining at the top notes which cannot be obviated when the upper resonance cavities are under repair. Still, in spite of all this, the concert was a thorough success, and the performance compared very favourably with those of previous years.

The first part of the performance opened punctually at 8 p.m., with a hearty, robust glee, "Life's a Bumper," by the Students' Glee Club, without accompaniment. It was sung with much vigor and dash and the pitch was sufficiently well maintained to show that they could discard the support of an instrument with considerable impunity. One can hardly pay the same tribute of praise to their later attempts, "The Hunter's Farewell" and "Lovely Night" (also sung without accompaniment) in which certain unruly voices appeared to run somewhat astray. One cannot help doubting whether the ambition which prompted so many essays into the deep without the life-belt was not more laudable than judicious. A trio, "Orpheus," by Ed. Gorman, was sung by the Nurses' Choral Society with much taste and formed a pleasing contrast to the romping glee of the students. Then followed a madrigal, "Matona," by the full choir. Though somewhat sombre, it was a good solid piece of work. The pianissimos would have been more effective, if some of the artistes could realize that to sing softly does not mean to sing without tone and with the lips closed.

Nurse Wood's rendering of the pretty, melodious "Birdie," Mendelssohn's duet, "I would that my love," by Messrs. Churchill and Stanley Hodgson; the trio, "Memory," sung by Nurse Daniell, Nurse Custance, and Dr. Spriggs; and Mr. Claxton's song, "To Althea, from Prison," were all well received.

Miss Spalding, who is always well appreciated at Guy's as a violinist for her excellent technique and perfect intonation, played the well known "Legende," by Wieniawski, with much skill and musical feeling.

Although the individual items of the programme so far were all good, yet, taken as a whole, one could not help feeling that the selection and arrangement were not altogether happy. Quiet, sombre music is all very well in its way, but too much of it becomes monotonous and has a depressing effect. A little more variety would have been acceptable. The change came none too soon when the full choir stood up to sing the bright and sprightly part song "Moonlight." It was, so far, the best achievement of the choir and their masterly rendering of it was rewarded by most enthusiastic applause. One could not help regretting that the programme contained so few part songs by the full choir; for the students and nurses united seemed to rise to a pitch of enthusiasm and perfection which they hardly reached in their separate efforts. Further evidence of this was given by the excellent rendering by the full choir of the two part songs, "The Bells of St. Michael's Tower" and "The Miller's Wooing," which opened and closed the second part of the programme, and both of which won encores, although time prevented response to the second encore.

Nurse Daniell, always thoroughly appreciated for the sweetness and melodiousness of her voice, was hardly at

her best in "Thoughts and Tears," by Hope Temple. Nevertheless, the audience pleaded earnestly for an encore. Prolonged fumbling of music ensued, but the needful piece could not be found, and the audience were disappointed. The Nurses' Choral Society then sang two very pretty duets, "Cleansing Fires" and "Greeting," and later on a trio, "Heaven." Mr. Soper gave a violin solo "Salut d'Amour," by Elgar, which he played with much expression, and as an encore he gave the more lively, "Un Soir à Portier," by Guido Papini. Mr. McD. Parrott thundered forth, "Thy Foe," in excellent style, and an encore being loudly clamoured for, he again delighted the audience with a most feeling rendering of "Speak," by Paolo Tosti. Nurse Daniell and Nurse Wood joined hands in a very pretty duet, "Fair Daffodils," by Mr. Henry Taylor, which they sang with much taste. The programme terminated with a hearty rendering of "God save the Queen," by the full choir.

In the middle of the second part the electric light gave ominous symptoms of sudden extinction, and the artistes, mindful of their recent experiences in wards and operating theatres smiled meaningly at one another, but the symptoms did not develop further and the performance terminated without any such disaster. Altogether, the concert was a most creditable performance and everyone thoroughly enjoyed the evening.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

A Hospital Corps.

DEAR MR. EDITOR,—In reply to your correspondent's letter on the subject of a Guy's Volunteer Corps, I think many men must consider the present a most auspicious time for such an institution, more especially because certain irregularities in the enrolment would enable many men to join who would be otherwise unable to do so. Some of these your correspondent has pointed out. Other features are that there would be no compulsory terms of enlistment such as characterise regular volunteer corps, and therefore resignation would be easy; also the time and place selected for squad drills would be chosen for our convenience. It would be essentially a Guy's squad, and the same patriotism which inspires our athletic teams would be sure to similarly encourage our men to make themselves efficient as volunteers, and so bring Guy's to the front in yet another way. Your correspondent's point as to non-subscription, is, I think, an important feature.—I am, Sir, yours faithfully,

D. W. SMITH.

DEAR SIR,—Might I trouble you to acquaint Dr. H. Stanley Turner with the fact that his scheme for the formation of a Hospital Volunteer Corps seems quite practicable, at least to me.—I remain, yours truly,

G. F. HARDY.

P.S.—I enclose a cutting from to-night's *Echo*:—

IMITATING THE BOERS.

About 40 men in the West Riding have enrolled themselves as a rifle club. The Lord Mayor of Leeds and the Mayor of Bradford have given their patronage. The main idea is that citizens should be trained on the same plan as the Boers. It is proposed to establish a riding club and to communicate with the military authorities as to facilities for practice and the supply of ammunition. Each member is to purchase his own rifle, and to pay a small annual subscription.

An Explanation.

DEAR SIR,—It has come to my notice that a paragraph penned by me which appeared in Passim of the 17th ultimo, has been taken too seriously by the persons criticised therein.

The criticism, I maintain, is just; my sense of humour is apparently much keener than that of many of my friends, who have chosen to mistake as offensive, comparisons which I considered purely facetious. In justice to myself, I must take this opportunity of correcting this erroneous view.—I am, Sir, yours truly,

F. G. GIBSON,
Hon. Sec. Rugby F.C.

Guy's Hospital, S.E.,
1st March, 1900.

Sport.

Rugby Football.

GUY'S v. ST. MARY'S.—INTER-HOSPITAL CHALLENGE CUP.—SEMI-FINAL ROUND.

(ST. MARY'S, 5 POINTS; GUY'S, NIL).

Having satisfactorily disposed of St. George's in the first, and St. Bart.'s in the second rounds, we met St. Mary's on Wednesday the 28th, and were beaten rather unluckily by 1 goal to nothing. We were without the services of Cutler, while Mullins and Jackson were both handicapped by lameness.

Mullins kicked-off against the wind, and as the return was a poor one, Mary's were at once penned in at the left corner. The scrums were keenly contested, and the honours just rested with Guy's, but all their efforts to score were frustrated by prompt falling on the ball by the defending forwards, and a marked disinclination to give up possession of it. The referee was decidedly kind to them in this respect, his attention being rather directed to off-side play, and both teams were penalised for this breach of the rules. About ten minutes after the commencement of play, Pye-Smith dashed through the loose pack and secured the ball; had he run up to the full-back before transferring to Sime, a certain score would have resulted, for the latter, failing to get round, was well brought down by Bradfield. Cowey now and then got

possession, one saw a cinematographic display of red stockings, one heard the roar of an admiring throng, followed by a thud, but little resulted from the dodgy Scot's efforts. For the first twenty-five minutes the ball was only once outside our half, and Harrison then returned with a fine kick into touch. Scrum followed scrum, rush succeeded rush, but we never got our wings to work, and the nearest to a score was a touch down at the end of half-an-hour, half-time arriving with nothing on the slate to the credit of either side.

On resuming play, we, from the line, thought that time and pressure would soon tell, but were disappointed when the visitors, charging down a return by Thomas, found themselves in our twenty-five for the first time in the game. Four scrums followed in quick succession, and in each the Mary's forwards secured the ball, and heeled it out in a manner which contrasted vividly with our own efforts in this respect; at last Soper passed out to Cowey, who transferred to Taylor, the latter kicked across the line before being tackled by Harrison, and Cheatle, though pursued by Trail, managed to touch down and gain a try, although he nearly lost the ball by knocking on when over the line; Wilson placed an easy goal. Our men at once rushed down into Mary's quarters, and pressed for some time, but were only really dangerous once, when O'Brien passed to Morgan, who centred well with a high kick, from which, however, a mark was secured. Sime subsequently made a good run, but was brought down by Cowey. Twice Mary's were forced down, and on each occasion gained a short respite by finding touch well from the drop-out. For the last quarter of an hour, Guy's made desperate efforts to get on even terms, but they were unable to break through the excellent defence of their opponents, who, in turn, once invaded our twenty-five with a passing rush among the three-quarters. Towards the close, the excitement ran very high, but our efforts were in vain, and time was called with the ball in mid-field, and the Cup no longer a resident of the Surrey side. Team:—

Guy's.—E. M. Harrison (back); A. O'Brien, C. D. Pye-Smith, E. Morgan and F. W. Sime (three-quarter backs); F. D. S. Jackson and M. Louisson (half-backs); R. C. Mullins, D. H. Trail, T. P. Thomas, P. T. Manson, K. V. Trubshaw, A. H. Wall, R. C. Lawry and E. H. Milsom (forwards).

Referee: Mr. W. Williams.

GUY'S 2ND XV. v. LENNOX 2ND XV.

(Guy's, 11 points; Lennox, nil).

This game—in the first round for the Surrey Cup—was played on our ground at Honor Oak on February 17th. The weather was anything but pleasant, as rain began shortly before the start, and continued in a steady and heavy downpour. This fact, added to the recent frost, snow, thaw and rain, made scientific play quite impossible.

Collins started the game about 3.30, and for the first ten minutes both sides seemed to be gauging each other. Then by better use of their feet and slight advantage forward, the game was taken to the Lennox twenty-five. The ball came out to Hicks, who dribbled, and being well backed up by Jarvis, the latter scored, but did not convert. On re-starting, Guy's again showed superiority, their forwards combined very well, and played a capital kick and rush game throughout. Brown got the ball well away from the scrum, but, probably owing to the slippery state of the ground and ball, it did not seem to get much further. A loose rush by the Lennox forwards threatened danger, but a miraculous single-handed effort by Nunn brought relief, and in fact led up to the next score. He stopped the ball with his feet, and by dribbling through the opposing forwards, rushed the ball over the line, and Hicks scored; Milsom converted. Half-time came soon afterwards.

Our men now kept the ball close, and by wheeling and rushing, wore out their opponents. Milsom was the most prominent, but was well backed up by all the others. Brown got away with a pretty run, but was unable to pass; then Hicks, who picked up the ball very smartly, looked like scoring, but was forced into touch. Twice did Lennox have to touch down in defence; our men were fairly outplaying them. From a cross kick by Hicks, and another by Kynaston, we nearly scored, but it was not until near the end that one of our forwards got over from a scrum on the line; the try was very wide and was not converted. Soon after, the game ended close to the Lennox line. Score:—Guy's, 1 goal 3 tries (11 points); Lennox, nil.

Association Football.

GUY'S v. R.M.A. WOOLWICH.

(Guy's 3 goals; Woolwich, nil).

Played February 7th at Woolwich and resulted in a win for Guy's by 3-0. We proved stronger than our opponents from start to finish, though they gave some very hard work at times. Goals were scored by Barber and Horsley. Team:—

Guy's.—S. P. Wadson (goal); W. M. Robson, A. Leeming (backs); F. M. V. Smith, N. P. Shepherd, C. Rust (half-backs); P. A. Peall, H. Barber, H. N. Lacey, C. Horsley, T. A. Chignell (forwards).

GUY'S v. BECKENHAM.

(Guy's, 1 goal; Beckenham, nil).

Played on February 24th, at Beckenham. From the regular team, Wiltshire, Shepherd, Robson and Edey were absent, their places being filled by Lacey, Rust, Smith and Brydone. The condition of the ground, in spite of so much rain previously, was all that could be desired, and the game was exciting from start to finish. In the first half, our forwards, well supported by the halves and backs, pressed considerably and had the better of the game, but half-time arrived with no score on either side. In the second half the play was more even, their forwards giving our defence plenty of work. About ten minutes after the interval, the ball was taken close up to our opponents' goal and put through by Norton. After this, Beckenham tried hard to equalise,

but our goal-keeper cleared their shots well, and though both sides made vigorous efforts, no further score was added, leaving Guy's victorious by 1–0.

Of the forwards, who played well, Barber was in the best form, and was unfortunate in not scoring. The defence was good all through, Bacon at centre half, and German, right back, being especially noticeable, while Wadson in goal was safe. Team:—

Guy's.—S. P. Wadson (goal); H. B. German, W. M. Robson (backs); F. M. Smith, H. Bacon, B. Rust (half-backs); T. A. Chignell, H. Barber, H. K. Lacey, E. L. Norton, F. Morres (forwards).

GUY'S v. EASTBOURNE.

(Guy's, 5 goals; Eastbourne, 1 goal).

This match which was played on the Saffron's ground, Eastbourne, brought a fairly successful season to a close with a well-merited victory. Eastbourne kicking-off up the slight slope, were soon surprised by Norton scoring for Guy's after a pretty bout of passing. This woke them up a little, and play ruled even for some time. After ten minutes' play, Eastbourne equalised with a fine shot by a piece of individual effort on the part of their left inside. But until change of ends no further score resulted, although Guy's had rather the best of the game, and put in many shots. After the re-start, Guy's, kicking off up the slope, put in a lot of hard work, and soon scored their second goal. Eastbourne were now playing with less steadiness, and when their back, through a miss-kick, gave us a third goal, they seemed to lose heart, and their play became wild and at times spiteful. The forwards now warmed up to their work, and all playing up hard and well, Chignell on the left-outside, and Barber in the centre, especially doing grand work, we soon scored two more goals, and held our lead to the finish. We thus beat Eastbourne for the first time in five years, by the respectable margin of 5 goals to 1. Team:—

Guy's.—Chignell, E. L. Norton, Barber, H. Hall, (sub.), Bacon, Shepherd, German, (sub.), C. Robson, Smith.

GUY'S 2nd v. St. THOMAS'S 2nd.

Inter-Hospital Junior Challenge Cup—Semi-Final Round.

Guy's, 2 goals; St. Thomas's, nil.

This tie was played off on Wednesday, February 28th, at Honor Oak Park, and resulted in a win for the Hospital by 2 goals to nil.

Guy's won the toss and Thomas's kicked off against a slight wind. For the first ten minutes play was very even, and then our forwards getting away, Dent, with a good shot at a difficult angle, opened the scoring. We continued to have the better of the game, and before half-time, Horsley, gaining possession of the ball after a neat run, passed to Roberts who added another point to our score.

The play during the second half was much slower and the exchanges more even. We were, however, unlucky in not adding to our score, as Peall, from a scrimmage in front of goal, netted the ball, but was ruled off-side, and Horsley hit the upright with a good shot. Two or three times Heap was called upon to save, and from a free kick, Thomas's put the ball through without it, however, touching anybody. Nothing further was added to the score, and Guy's thus qualified to meet Mary's in the final. Considering the state of the ground, the team, on the whole, played a good game, and ought to give Mary's a hard fight for the cup. It is to be hoped that men will turn up to see the final, which will probably be played early next week. Team:—

Guy's.—E. T. Heap (goal); A. Leeming, E. Corfe (backs); J. Brydone, P. V. C. Bent, B. Rust (halves); H. L. Dent, W. O. Roberts, C. Horsley, H. K. Lacey, P. A. Peall (forwards).

United Hospitals Hare and Hounds.

St. Thomas's failing to turn out a team on Saturday 17th, the result was a walk over for Guy's and so the Cup remains in the Smoking-room. An ordinary run was held over the long forest course, and the following took part in the run:—N. C. Birt, R. E. Brayne, S. J. Ormond, P. G. Easton, D. L. Morgan, R. S. Roper.

In the sprint home, Birt came in first, followed closely by Roper, Brayne and Ormond. As only five were running, the handicap was abandoned. The runs have been so poorly attended lately that it was decided not to hold any more meetings this season.

And this is what a once flourishing Cross-Country Club has come to! No competition, no handicap and no members. Simply owing to men not turning out!

There are quite a large number of men who can and do run sometimes at Chingford, but they are too slack to turn out regularly. It seems a pity that a sport of this kind should die out among the hospitals, but unless the club is better supported, February, 1900 will be the date of the death of a once famous Cross-Country Club.

From the Gazette's Special Pathologist.

J. D. M., Hoddesdon.—Tubercle bacilli are present in the sputum in small numbers.

M. W. O., Mansfield,—The growth on blood-serum after incubation, consists of staphylococci and streptococci. The Klebs-Loffler bacillus was not found.

PATHOLOGIST.

CORRECTION.

The price of Miss Oxford's Manual of Nursing was erroneously given at 6s. It should be, of course, 3s. 6d.

Births.

FAGGE.—On February 20th, at 22, St. Thomas's Street, S.E., the wife of Charles H. Fagge, M.S., F.R.C.S., of a daughter.

PEDLEY.—On February 7th, at Tonbridge, Kent, the wife of George Aston Pedley, L.R.C.P., L.S.A. Lond., M.R.C.S., L.D.S. Eng., of a son.

Marriage.

ROWLAND—PLUMER.—On February 20th, at Shoreham, Sussex, Walter John Rowland, B.A. Lond., M.B. Dunelm., M.R.C.S., L.R.C.P., of 10, College Road, Brighton, to Jessie, fourth daughter of Alfred Saxby Plumer, Esq., of Steyning, Sussex.

Ed.—S. H.

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Calendar of Coming Events.

March, 1900.

Sat. 17.—Messrs. Lucas and Lane's take-in; Drs., N. F. Ticehurst and F. W. Sime; Cl., O. Marriott.
1 p.m. Clinical lecture by Dr. Taylor.
G.H.R.F.C., I.—London Irish, away.
G.H.P.P.S., Clinical Evening.

Mon. 19.—Last day for sending in Fees and Certificates for Camb. D.P.H.

Tues. 20.—Dental Anatomy Exam. for 1st and 2nd Year's Prizes, 2 to 5 p.m.

Wed. 21.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.
Exams. for Junior and Senior Prizes for General Proficiency, and for the Michael Harris and Wooldridge Prizes.
Dental Physiology Exam. for 1st and 2nd Year's Prizes, 10 a.m. to 12 noon.
Dental Anatomy Exam. for 1st and 2nd Year's Prizes, 2 to 5 p.m.

Thur. 22.—Messrs. Golding-Bird and Dunn's take-in; Drs., R. D. Smedley and R. Thomson; Cl., A. H. Davies.
Exam. for Golding-Bird Gold Medal and Scholarship begins.
Dental Surgery Exam. for 2nd Year's Prize, 2 to 4 p.m.

Sat. 24.—1 p.m., Clinical lecture by Dr. Taylor.
Debating Society, "Ladies' Night," 8 p.m. Court Room.
Lectures cease.

Mon. 26.—Exam. Pract. Dent. Metallurgy, 3 p.m.

Tues. 27.—First Conjoint Exam. begins.

Wed. 28.—School Exam. in Elementary Anatomy.

Thur. 29.—Messrs. Jacobson and Fripp's take-in; Drs., E. T. Claxton and G. S. Davidson; Cl., W. G. Stewart.
Second Conjoint Exam. begins.
Winter Session ends.

Fri. 30.—Annual General Meeting Students' Club, 4 p.m.

Sat. 31.—Last day for applying to Registrar for Form of Entry for Final M.B. Lond.

Guy's Hospital Gazette,

MARCH 17, 1900.

Hæmoptysis.

CLINICAL LECTURE BY DR. BRYANT.

January 27th, 1900.

GENTLEMEN,—I have recently had under my care in John ward, a patient suffering from Hæmoptysis. Twice before I saw him he was seen and examined, and on both occasions was diagnosed as suffering from hæmatemesis due to cirrhosis of the liver. After determining that he was suffering from hæmoptysis, and not from hæmatemesis, the differential diagnosis of the actual cause of the hæmoptysis presented a good many difficulties. These reasons I have considered sufficient excuse for taking this case as the text for a clinical lecture on hæmoptysis. I shall read to you some notes of the case which I have obtained from the excellent report of Mr. F. G. Cross. I shall then point out the differences between hæmoptysis and hæmatemesis, then discuss the differential diagnosis of the causes of hæmoptysis, giving a brief account of the pathology and morbid changes associated with each variety.

The patient is a male, aged thirty-eight, and was admitted, under my care, into John ward, on January 1st, 1900, for hæmoptysis. His father suffered from gout and died of heart disease, one of his brothers suffers from gout; there is no history of tubercle. The patient is married and has three healthy children. Sixteen years ago he had a vesical calculus removed, and fifteen years ago he had an attack of typhoid fever. He takes about five or six pints of beer a day, and two or three "rums" before breakfast. For the last twelve months he has complained of a heavy sick feeling when he first

gets up in the morning. He has never had syphilis. Five years ago he came to the front surgery suffering from epistaxis; there has been no recurrence until last Christmas, when he had another slight attack.

On January 1st he had been in bed about an hour when he felt a gurgling sensation in his throat and found his mouth full of blood; he thinks he brought up about half a pint. He did not retch, nor was there any cough or choking sensation, but it seemed to well up into his throat. He at once came to the hospital, was seen by the house-physician, who told him to go home and rest, and gave him a card for the out-patient department. He came up at 1 p.m. to my out-patients, when I saw him; he was then coughing up bright, red, frothy blood. I made a very superficial examination and came to the conclusion that it was a case of cardiac hæmoptysis. He was admitted into Clinical ward and at once put to bed.

Condition on admission—He is a big, stout man, with a florid complexion, and with small, dilated venules on his nose and cheeks. The sclerotics are very slightly jaundiced. There are no tophi visible. The fingers are not clubbed. There is no anasarca.

Alimentary system.—The tongue is not furred. The bowels are constipated. There are no hæmorrhoids. The abdomen is large and flabby. The edge of the liver can be felt two inches below the costal margin, in the right nipple line; it is hard, and the surface, as far as could be determined, is smooth. The spleen could not be felt. The chest is very emphysematous. A few faint rhonchi are heard at the bases. There are no signs of phthisis.

The sputum.—At out-patients he coughed up a good deal of bright, red, frothy blood-stained sputum.

Circulatory system.—Pulse 82, regular, low tensions, artery not thickened. The cardiac impulse cannot be seen or felt. The area of cardiac dulness is smaller than normal on account of the emphysema. In the fifth space, about half an inch inside the left nipple-line, a distinct blowing systolic murmur can be heard; it can be traced outwards into the axilla for two inches, but better inwards for two inches towards the left border of the sternum. The second sound at the base of the heart is loud.

Urine.—Sp. gr. 1018. Very slight trace of albumen. No blood. Urea 3 per. cent.

He was allowed ice to suck, and was kept on a milk diet. The following mixture was prescribed:—

Tinct. Opii.	... ...	ɱv.
Acid Sulph. Aromatici	...	ɱx.
Syr. Balsam Tolutani	...	ʒi.
Aquam ad.	... ...	℥i.

6tis. horis.

January 3rd. He hasbeen kept quite quiet, lying on his back, and he is much better. He still spits up blood-stained sputum, which is now more of a brownish than a red colour.

4th. Better. Sputum still brownish in colour.

5th. He was allowed to get up after tea.

8th. He went out feeling perfectly well. With the exception of emphysema nothing abnormal could be detected in the lungs. The sputum was examined for tubercle bacilli, but with a negative result.

Now, the first point of interest is, that on two occasions, *i.e.*, when seen by the house-physician in the early morning, and by the clerk in the out-patient department, he was thought to be suffering from hæmatemesis. This mistake was made on account of the alcoholic history, the alcoholic appearance of the patient, and the enlargement of his liver. A careful examination of the blood brought up, and the symptoms associated with it, would have shown that in spite of the evidence of alcoholism and cirrhosis of the liver, the blood had come from the lungs, and not from the stomach.

When you are called to see a patient who has been bringing up blood, your first consideration must be to determine whether it is a case of hæmoptysis or hæmatemesis. These two conditions can only be distinguished by carefully enquiring into the history of the symptoms, by an examination of the blood which has been brought up, and a careful physical examination. When I saw this patient in the out-patient department he clearly stated he had coughed up the blood, that he had not been sick and had not even felt sick. He described the blood as being bright red in colour, frothy, liquid, and not in clots, and on examination it proved to correspond exactly to his description. From these data it was obvious that the condition was hæmoptysis and not hæmatemesis. In hæmoptysis, therefore, the blood is coughed up, and a tickling or gurgling sensation in the throat, such as this patient experienced, is not an uncommon premonitory symptom; the blood may be mixed with the sputa; the amount of blood may vary from a few streaks to a pint or more; it is bright red in colour and frothy, it is usually liquid when it is brought up, but may coagulate in the vessel which receives it; it is

alkaline in reaction. If the hæmoptysis is very profuse the blood may simply pour out of the mouth in a stream and rapidly prove fatal. After hæmoptysis has occurred the sputa may be blood-stained for several days; at first it is bright red in colour, but subsequently becomes darker and of a brownish tinge.

In hæmatemesis the blood is vomited and may in consequence be mixed with particles of partly digested food. If the hæmorrhage is considerable the blood may be bright red in colour, and liquid, or clots of blood which are not at all or only slightly altered in colour may be noticed. If the hæmorrhage has been gradual and blood has remained for some little time in the stomach, as it commonly does in contact with the acid gastric juice, it becomes of a brownish colour and has been likened in appearance to coffee-grounds. The cause of the alteration in the colour is the action of the gastric juice which converts the oxyhæmoglobin into hæmatin. It is acid in reaction. The following summary shows at a glance the differences between hæmoptysis and hæmatemesis:—

Hæmoptysis.	Hæmatemesis.
1. The blood is coughed up.	1. The blood is vomited.
2. The blood is bright red in colour and frothy; it is never watery.	2. The blood is dark in colour and not frothy.
3. The blood may be mixed with sputa.	3. The blood may be mixed with vomit.
4. The blood is alkaline in reaction.	4. The blood is acid in reaction.
5. There may be a previous history pointing to pulmonary or cardiac disease.	5. There may be a previous history pointing to gastric or hepatic disease.
6. Before the blood is coughed up there is often a sense of tickling or gurgling in the throat.	6. Before the blood is vomited there may be a feeling of sickness, oppression in the epigastrium, faintness and giddiness.
7. The motions afterwards are not altered unless the patient swallows a good deal of the blood when they may be tarry.	7. The motions after are tarry in appearance.
8. Blood-stained sputa may be expectorated for several days after the attack.	8. There is usually no sputa.

These are the differences between the two conditions.

The next point is, that hæmatemesis may be caused by hæmoptysis. This is most likely to occur when the bleeding takes place in the night, the blood being swallowed as soon as it gets into the pharynx, the patient remaining asleep and quite unconscious of the occurrence. Sir Samuel Wilks has drawn attention to the frequency with which hæmoptysis occurs during the night when the patient is at rest; in the majority of instances the incidence of bleeding excites coughing, and the patient wakes. I remember seeing a case which illustrates this point. One morning, when I was Medical Registrar, I came to a woman who had been admitted on the previous day for general weakness and a history of bringing up blood. At about 8 a.m. that morning she had vomited a rather large quantity of dark brownish vomit, which resembled in appearance, and proved on examination to be altered blood. Those who had already seen her had diagnosed hæmatemesis, and had suggested gastric ulcer or cirrhosis of the liver as its probable cause. A careful examination of the front of the chest, care being taken not to move the patient, and percussion as a part of the examination being omitted, revealed very definite signs of phthisis at the left apex, viz., flattening, deficient movement, bronchial breathing and consonating râles. A subsequent examination of the sputa showed the presence of tubercle bacilli, and for some days after the hæmorrhage the sputa were streaked with blood. There were no signs of gastric ulcer, malignant disease of the stomach, or cirrhosis of the liver. The explanation of the blood being vomited was that hæmoptysis had occurred during sleep, and that the blood had been swallowed as soon as it reached the pharynx. In a small proportion of the cases of hæmatemesis caused by cirrhosis of the liver, signs of phthisis may be found, as alcoholism not only causes cirrhosis of the liver, but is an important predisposing cause of phthisis.

Having arrived at the conclusion that the patient was suffering from hæmoptysis, the next point to ascertain was the cause of this very important symptom.

Hæmoptysis may result from morbid changes n the lungs, bronchi, trachea and larynx.

Causes of Hæmoptysis.

A. *Changes in the Lungs.*

1. Phthisis.
2. Congestion.
   - Cardiac disease, especially mitral stenosis.
   - Pressure on the pulmonary veins.
     - Growth.
     - Enlarged glands.
     - Aneurysm, &c
   - From violent coughing efforts, *e.g.* whooping cough.
3. Injury.
   - Wounds.
   - Rupture.
4. Pneumonia.
5. Acute tuberculosis.
6. Caseous bronchopneumonia.
7. Infarct.
8. Carcinoma.
9. Sarcoma.
10. Hydatid.
11. Syphilis.
12. Emphysema.
13. Gangrene.
14. Abscess.
15. Atheroma of the pulmonary arteries (primary).
16. Aneurysm of the aorta pressing on and opening into the lung.

B. *Changes in the trachea and bronchi.*

1. Ulceration
   - Syphilitic.
   - Malignant.
   - Secondary to foreign body.
2. Bronchitis
   - Acute.
   - Chronic.
   - Plastic.
3. Bronchiectasis.
4. Aneurysm opening into the trachea or a bronchus.
5. Primary malignant growth of bronchus.
6. Malignant growth of the œsophagus or mediastinum invading the trachea or a bronchus.
7. Ulceration of the trachea opening into the aorta (*e.g.*, following tracheotomy).
8. Perforation of the pulmonary artery by an ulcer of the bronchus, caused by pressure of a calcareous bronchial gland. (Kidd.)
9. Parasitic—The distomum westermanii.

C. *Changes in the larynx.*

Ulceration
- Malignant.
- Syphilitic.

D. *Blood diseases.*

Purpura.
Scurvy.
Hæmophilia.
Leucocythæmia.
Malignant variola, &c.

E. *Vicarious menstruation.*

F. *Recurring hæmoptysis in arthritic subjects.* (Andrew Clark).

G. *In young healthy subjects.* No obvious cause.

True hæmoptysis, *i.e.*, hæmorrhage from the lungs, bronchi, trachea, or larynx must be distinguished, first of all, from spurious hæmoptysis by which is meant the spitting of blood derived from the nose, mouth or pharynx, *e.g.*,

Epistaxis.
Ulceration of the pharynx.
Stomatitis.
Malingering (sucking the gums, etc.).

A careful examination of the nose, mouth, gums, and pharynx will generally suffice to distinguish this condition, and further, the blood is generally watery, mixed with saliva, and non-aerated. There was no evidence of any morbid condition affecting the above mentioned parts in the patient under consideration.

Phthisis is by far the commonest cause of hæmoptysis. It may be the very first sign of the disease or may be the last, the hæmorrhage being so severe as to cause the patient's death. The amount of blood brought up is very variable. The sputum may be only streaked with blood, or a pint or more of almost pure blood may be expectorated. In advanced stages of phthisis the diagnosis is not difficult. The flattening, deficient movement, increased tactile vocal fremitus, bronchial breathing, consonating râles, bronchophony and pectoriloquy at one apex, with signs of less advanced disease at the other apex, are distinctive, and the examination of the sputum showing the presence of tubercle bacilli, is conclusive. As above stated, hæmoptysis may be the first evidence of phthisis, the diagnosis is then difficult as the physical examination may not reveal any abnormal signs. Tubercle bacilli may be found in the sputa, however, at this stage, so that a careful examination of the sputa must always be made before a definite or reliable opinion as to the cause of the hæmoptysis can be given. With the exception of emphysema there was no evidence of disease of the lungs in this patient, no tubercle bacilli could be found in his sputum, and he had not suffered from cough or wasting. There was evidence, however, of a definite

cardiac lesion. So that, taking all these points into consideration, a diagnosis of cardiac hæmoptysis was made, and not phthisis.

It is a very rare condition to find phthisis associated with chronic valvular disease of the heart, unless it happen to be congenital in origin. This was another point against the diagnosis of phthisis. I shall discuss the diagnosis of the actual cardiac lesion after I have given you a short account of the causes of hæmoptysis associated with phthisis. In phthisis the actual cause of the hæmoptysis is not constant; it may be due to a variety of different conditions.

A 1.—(1) In the early stages of the disease it may be the result of an *inflammatory hyperæmia*, with rupture of the capillaries; the amount of blood expectorated is usually small and may only amount to streaking of the sputum.

(2) The small vessels may actually become inflamed and softened or become infiltrated with tuberculous changes, and, in consequence, rupture if any extra strain is suddenly put upon them, *e.g.*, attacks of coughing. This condition may lead to a more profuse hæmoptysis; it may occur quite early in the course of the disease.

(3) When the disease is more advanced the caseation and the breaking down of the lung tissue may lead to the tearing across of one of the larger branches of the pulmonary artery. This change does not always lead to hæmorrhage, as the lumen of the affected vessel may previously, as a result of the adjacent changes in the lung, have become blocked by a thrombus. I have here a specimen of this nature from the museum, and also another from a post-mortem examination that I performed quite recently. In both these specimens a branch of the pulmonary artery is torn across, and about an inch of the vessel is lying free in the vomica, but in each the lumen of the vessel is closed by an ante-mortem thrombus. Such a condition, however, may cause a very profuse hæmorrhage if there is no thrombus.

(4) The most important cause, is the rupture of aneurysms of branches of the pulmonary artery in cavities in the lung. These aneurysms may be saccular or fusiform in shape, and may vary in size from a pin head to a pigeon egg. They are formed in this manner. A cavity in the lung is formed by the breaking down of the areas of caseation. In this process, branches of the pulmonary vessels may be exposed on the walls of the cavity, and this leads to a weakening of the vessel wall on the side bordering the cavity, on account of the loss of support entailed by the destruction of the lung tissue. The vessel wall may also be softened as a result of arteritis, and so this weakened patch in the wall of the vessel may yield to the blood pressure, expand and form a small saccular aneurysm which bulges into the cavity. Occasionally a vessel will be seen stretching across a cavity; such a vessel will have lost all surrounding support and may therefore dilate in all directions, and thus form a fusiform aneurysm. The rupture of such an aneurysm will cause a very sudden and profuse hæmorrhage which may rapidly be fatal. I show you this specimen (produced) from the museum. The patient I remember seeing in Mary ward. She brought up an enormous quantity of blood, and died from syncope. I performed the necropsy and found a ruptured aneurysm about half an inch in diameter, in a cavity in the right lower lobe.

(5) In the same week I remember seeing another patient who died as the result of hæmoptysis, and I also performed the necropsy in this case. The lungs showed signs of very advanced phthisis, the left upper lobe contained a large smooth-walled cavity, the wall of which was red and infiltrated with blood. I looked very carefully but could find no trace of an aneurysm in either lung. The appearance of the cavity suggested that the cause of the hæmorrhage was a general exudation from the small vessels in the wall of the cavity.

Next to phthisis *chronic valvular disease of the heart*, especially mitral stenosis, is the commonest cause of hæmoptysis. I have already stated that I considered the hæmoptysis in this particular case was the result of cardiac disease. I did not, however, think the cardiac disease was mitral stenosis, for the physical signs did not point to this lesion, and the absence of a history of rheumatism, chorea, or scarlet fever was also against this view. I came to the conclusion that he was suffering from mitral regurgitation, the result of dilatation and hypertrophy of the left ventrical, the primary cause of which was chronic alcoholism. I have now performed a good number of post-mortem examinations on cases in which I have found hypertrophy and dilatation of the heart with all the signs of backward pressure, without there being any disease of the valves, blood-vessels, or kidneys, in all of which cases there was good evidence of long-continued alcoholism. Alcoholism as a cause of hypertrophy and dilatation of the heart has been recognised at this hospital for some time.

The cause of hæmoptysis in heart disease will be best understood if I describe to you the changes which take place in the lungs as a

result of the backward pressure which is set up by stenosis or incompetence of the mitral valve.

A 2.—(1) The first result will be an obstruction to the flow of blood through the pulmonary veins, in consequence of which they themselves and their capillaries become over-distended with blood (passive congestion of the lungs).

(2) In addition there may be a transudation of serum and red blood corpuscles into the tissues of the air vesicles and into the air vesicles themselves, giving rise to hæmorrhagic œdema.

(3) In more advanced cases the lung becomes tough, semi-solid, and partly airless, smooth on section, and dull red in colour. From its resemblance on section to a section of the spleen this condition is called *red splenization or red induration*. The condition is due to a mixture of congestion of the pulmonary vessels—the capillaries of which are dilated, thickened, and varicose—œdema, and actual hæmorrhage.

(4) In a still later stage the colour becomes brown from changes taking place in the blood pigment which has exuded into the connective tissues of the lung. That condition is called *brown induration*.

(5) The lining membrane of the smaller bronchi may show signs of engorgement, and blood may exude from its surface.

(6) Infarcts of various sizes may be found, dependent on the size of the vessels obstructed. The obstruction of the branch of the pulmonary artery involved may be the result of embolism or thrombosis. If due to embolism it has been caused by of the backward pressure which has produced stagnation of blood in the appendix of the right auricle, with consequent thrombosis; the separation of a piece of this thrombus has furnished the embolus. If due to a primary thrombosis, the thrombus has been caused by the stagnation of the blood in the implicated vessel itself. The infarct is usually subpleural, is firm in consistence, and of a dark, brownish-red colour. The lung tissue becomes denucleated and necrotic, and the alveoli are filled with coagulated blood. The pleura over the infarct is usually inflamed. A considerable amount of dark blood may be expectorated when infarcts are present.

(7) Another important change which is almost invariably found in these so-called cardiac lungs is thickening, dilatation and atheromatous degeneration of the pulmonary arteries, a condition brought about by the greatly increased tension produced in these vessels as a result of the backward pressure. Rupture of small branches of such degenerated pulmonary arteries also give rise to hæmoptysis.

A 3.—In cases of *injury* the lung is either wounded or ruptured, and the blood is derived from the severed branches of the pulmonary arteries or veins. There is usually a history of or evidence of the injury.

A 4.—In *pneumonia* the amount of blood expectorated is in the majority of cases slight. The sputum is thick, viscid, tenacious, and generally of a russet-brown colour; It may, however, be bright red. At this stage there is inflammatory hyperæmia of the pulmonary capillaries and actual exudation of blood into the air vesicles. This disease is distinguished by the acute onset, the temperature, pulse and respiration ratio, the characteristic appearance of the sputa and the presence of capsulated diplococci.

A 5.—In *acute tuberculosis* the sputum may be tinged with blood, and it is usually the result of inflammatory hyperæmia. The rapid prostration and wasting, the remittent fever, the cyanosis, and the presence of tubercles in the choroid would point to acute tuberculosis.

A 6.—In *caseous bronchopneumonia* rapid breaking down of the lung tissue may occur, and free hæmoptysis may result from the rupture or erosion of branches of the pulmonary vessels. I quite recently had under my care a patient suffering from this disease. His illness commenced with rather free hæmoptysis and pyrexia, and a diagnosis of incipient phthisis was made. Four or five days after the onset, as signs of consolidation of the lung were found at the right base, and as the temperature had been high and continuous since the onset, lobar pneumonia was considered. This view was given up when it was found that the temperature still remained high at the end of a fortnight, and that the signs of consolidation were increasing, so a diagnosis of tuberculosis, probably tuberculous bronchopneumonia, was made. He wasted, became cyanosed, the temperature remained high, and the physical signs increased in extent until he died in the fifth week from the onset. Extensive tuberculous brochopneumonia with recent cavitation was found.

A 7.—*Infarction of the lung* I have already mentioned in connection with its most frequent cause, heart disease. It may also occur as a result of embolism secondary to thrombosis of the systemic veins, infective endocarditis of the pulmonary or tricuspid valves, and from primary thrombosis as in leucocythæmia. A large infarct might give rise to pain, and on examination

a local patch of dulness with bronchial breathing and a pleuritic rub might be detected. Hæmoptysis associated with such physical signs and accompanied by evidence of endocarditis or venous thrombosis would suggest infarct as the cause of it.

A 8 and 9.—*Carcinoma and sarcoma of the lung* are usually secondary. The primary seat of the growth may be the bronchus, œsophagus, breast, mediastinal glands, stomach, etc. The sputum may be tinged with blood, or it may be dark in colour and resemble in appearance currant jelly. Occasionally hæmorrhage is profuse. Hæmoptysis may be due to hyperæmia and to breaking down of the growth, with ulceration or rupture of the branches of the pulmonary vessels, or the growth itself may be very vascular. A large number of cases of malignant growth in the lung are accompanied by pleuritic effusion, and growth may not at first be suspected. If aspiration is performed the fluid is generally found to contain blood. Another important effect of growth is invasion of or pressure on a bronchus. The physical signs are deficient movement, deficient or absent tactile vocal fremitus, dulness, deficient or absent breath sounds and vocal resonance, and accompanying these physical signs progressive weakness and emaciation; no tubercle bacilli are found in the sputum. I remember seeing a case of malignant growth of the lung presenting similar symptoms and physical signs to those I have mentioned, in which the malignant growth had grown into a bronchus, forming a kind of cast of it which broke off and was expectorated. A microscopical examination showed it to be malignant in character, and although malignant disease of the lung had been diagnosed, it helped to confirm the diagnosis. That was one of the most extraordinary cases I have ever seen.

A 10.—*Hydatid of the lungs.*—This is most commonly secondary to hydatid of the liver. Hæmoptysis is one of the most important symptoms; it may be the result of inflammatory hyperæmia, or actual destruction of lung tissue, as hydatid cysts may cause compression of the lung, and may set up pneumonia or gangrene. The sputum may contain shreds of hydatid membrane, daughter cysts, scolices and hooklets. The physical signs are, perhaps, some local bulging of the thorax, dulness, deficient vesicular murmur, and vocal resonance. These signs may be associated with local enlargement of the liver. Dr. Taylor mentions in his book on Medicine, a case which was mistaken for phthisis. "A girl with cerebral tumour, in Guy's Hospital, had hæmoptysis, and was thought to have tubercle of the brain and pulmonary phthisis, but a hydatid cyst was found in both brain and lung."

A 11.—*Syphilis* may cause ulceration of the larynx, trachea, or bronchi, and hæmoptysis may result, blood-vessels supplying these parts being involved and eroded. It may also give rise to the formation of gummata in the lungs. The gummata may soften, break down and form cavities, and hæmoptysis may result from the formation and rupture of pulmonary aneurysms, as in phthisis. Hæmoptysis is, however, rare; it is most likely to be mistaken for phthisis. A history or evidence of syphilis, and the absence of tubercle bacilli in the sputum would point to syphilis.

A 12.—*In emphysema* the sputum may occasionally be streaked with blood, which may be derived from a congested bronchial mucous membrane, or from the rupture of small capillaries in the walls of the air vesicles. The physical signs are sufficiently distinctive.

A 13.—*In gangrene of the lung* there is a good deal of destruction of the lung tissue, in the course of which pulmonary vessels may be opened. It may be distinguished from other diseases of the lung by the extremely fœtid and penetrating odour of the breath, and by the sputum, which is also extremely fœtid, of a greenish-brown or dirty-grey colour, and containing fragments of necrosed lung tissue, and putrefactive micro-organisms.

A 14.—*Single abscess of the lung* is extremely rare. Multiple abscesses may be found as a part of a general pyæmia. The sputum may be streaked with blood, the result of inflammatory hyperæmia.

A 15.—*Primary atheroma of the pulmonary arteries* is another very rare condition. If any undue strain is put upon the lung, when this change is present, such as violent coughing efforts, small branches of the vessel may give way and lead to slight hæmoptysis.

B 1.—Syphilitic, malignant, or tuberculous ulceration of the trachea or bronchi, may cause hæmoptysis by erosion of branches of the bronchial vessels.

B 2.—In *bronchitis* the sputum is occasionally streaked with blood which is derived from the congested blood-vessels of the bronchial mucous membrane. The physical signs, viz., mucous râles and sibilant or sonorous ronchi, which can be heard all over the chest, are characteristic of this disease. Plastic bronchitis is distinguished by the characteristic sputum, casts of the bronchi being expectorated in this disease.

B 3.—*Bronchiectasis* frequently gives rise to profuse hæmoptysis. It may be due to congestion of the bronchial vessels, or to the rupture of an aneurysm of a branch of the pulmonary artery protruding into a dilated bronchial tube. I have now seen a good number of these cases, and they are almost invariably admitted into the hospital as cases of phthisis. A careful physical examination and an examination of the sputum should enable you to make a correct diagnosis. Bronchiectasis, when it gives rise to hæmoptysis, is usually associated with fibroid change which is not tuberculous in origin. The physical signs of such a condition are: Flattening and deficient movement on the affected side, displacement of the cardiac impulse towards the affected side, *e.g.*, when the right side is affected the cardiac impulse may be in the fifth right space in the right nipple line—increased tactile vocal fremitus, dulness, bronchial breathing, or even cavernous or amphoric breathing over a largely dilated tube, bronchophony, pectoriloquy, and loud consonating râles. With the exception of some compensatory emphysema the other lung may show no evidence whatever of any morbid change. Another characteristic sign of bronchiectasis is the expectoration of a large quantity of sputum, half a pint perhaps or even more, in the early morning, soon after the patient wakes and begins to move about. In phthisis, if one lung should give signs of such advanced disease, there would certainly be evidence also of disease in the other lung. You have never seen in the post-mortem room the whole of one lung effected by phthisis and the other quite free. In fibroid lung and bronchiectasis, on the other hand, you may have seen, or will see cases in which the whole of one lung is affected, the other being quite free.

B 4.—*An aneurysm of the aorta* may open into the trachea or a bronchus; the hæmorrhage in such cases is usually profuse and rapidly fatal. Occasionally a slight leakage causing moderate hæmoptysis may first occur. An aneurysm may also press on the lung and open into it, giving rise to hæmoptysis in this way. Before opening into the trachea or a bronchus, an aneurysm usually first erodes the cartilages, and then bulges into the lumen of the trachea or bronchus. Aneurysm must be distinguished by a careful physical examination. A tumour, pain, pulsation, a bruit, and signs of pressure, *e.g.*, inequality of the pulses, unequal pupils, recurrent laryngeal paralysis, and tracheal tugging. I have already alluded to primary growth of a bronchus as a cause.

B 5.—(1) *Œsophageal growth* may cause hæmoptysis by invading the lung or trachea. It is usually preceded by dysphagia and rapid emaciation, and the diagnosis is not as a rule difficult.

(2) *Mediastinal growth* may invade the lungs, trachea or bronchi, and thus cause hæmoptysis. It is distinguished chiefly by its pressure effect on the superior vena cava which gives rise to œdema of the arms, neck, and upper part of the chest.

(3) In China, Japan and Formosa hæmoptysis may be caused by a parasite, the distomum westermanii, which invades the bronchial mucous membrane.

C. Ulceration of the larynx may cause hæmoptysis by erosion of the laryngeal vessels. It may be distinguished by signs of laryngeal disease, huskiness, aphonia, pain, &c., and by laryngoscopic examination.

D. Blood diseases may give rise to hæmoptysis as well as to hæmorrhage from other parts. It may be due to changes in the vessels, or to an alteration in the condition of the blood, both of which conditions may lead to hæmorrhage. The history of the case, the general appearance of the patient, and a careful examination will generally suffice to make the diagnosis of hæmoptysis from any of these causes quite clear.

E. *Vicarious menstruation* is one of the conditions which is nearly always given in textbooks as a cause of hæmorrhage from the lungs, nose, stomach, &c. It is of rare occurrence. I have never seen a case of this nature. Osler mentions that Flint has had a case under observation for four years.

F. Sir Andrew Clark, in the Medical Society's Transactions (vol. 13, p. 9), described a form of hæmoptysis which was non-tubercular and non-cardial, which occurred in people over fifty years of age, the subjects of chronic arthritic changes.

G. Hæmoptysis occasionally occurs in young healthy subjects, and may disappear in a few days, never occur again, and leave no physical signs indicative of disease of the respiratory organs. Such cases should, however, be very carefully watched, as hæmoptysis coming on in this manner may be the first indication of phthisis. I was hoping to be able to tell you something about the treatment of hæmoptysis, but I am afraid I have not time as it is now two o'clock.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Hale White.

Mary
14. Gall-stones.
16. Pernicious anæmia.
17. Phthisis.
19. Exophthalmic goître.
20. Mitral stenosis.
21. Post-influenzal neuralgia. V. & VI. (C.N.)
23. Tertiary ulceration of rectum.
24. Epidemic cerebro-spinal meningitis.

Philip
1. Pneumonia.
3. Pyo-pneumothorax. Operation.
4. Diabetes. Gangrene of toe.
5. Empyema ruptured into lung.
6. Phthisis.
7. Mitral and tricuspid disease.
8. Thickened pleura.
9. Chronic nephritis. Emphysema and bronchitis.
10. Diabetes.
12. Ulcerative colitis. Colotomy.
13. Hemiplegia.
15. Mitral disease.
16. Pericardial effusion.
18. Aortic disease.
19. Cirrhosis hepatis.
20. Infective endocarditis.

Cases under Dr. Pitt.

Mary
29. Colitis.
30. Pleurisy with effusion.
32. Chlorosis.
33. Cerebellar tumour. Optic atrophy.
35. Mitral stenosis.
36. Alcoholism. Enlarged liver.

Stephen
22. Carcinoma hepatis.
25. Lobar pneumonia.
27. Enteric.
28. Mitral disease.
29. Aortic and mitral disease. ? Adherent pericardium.
32. Enlarged liver. ? Cause.
33. Enteric.
36. Chronic nephritis.
38. Acute nephritis.
40. Chronic phthisis.

Cases under Dr. Perry.

Mary
1. Exophthalmic goître. Gastric ulcer.
2. Hydronephrosis. Operation. Congenital heart.
3. Abscess in right hypochondrium. ? Gall-stone.
7. Pernicious anæmia.
8. ? Cerebral tumour.
9. Perihepatitis. Ascites.

Stephen
2. Spastic paraplegia. Primary optic atrophy. ? G.P.I.
5. Pseudo-hypertrophic muscular paralysis.
9. Basal phthisis.
10. Friedreich's ataxia.
14. Congenital spastic paraplegia.
15. Tuberculous peritonitis.
20. Fibroid lung.

Cases under Dr. Shaw.

Mary
38. Chronic constipation.
39. Albuminuric retinitis.
40. ? Uræmia.
42. Pleurisy with effusion.
43. Pleurisy with effusion.
45. Chorea. Paralysis of arms and legs.
46. Carcinoma of stomach.
47. Gastric ulcer.
48. Gastric ulcer.
49. ? Addison's disease.
50. Motor aphasia.

Philip
21. Hydatid cyst between liver and diaphragm. Operation.
22. Mitral stenosis. Tricuspid regurgitation. Cirrhosis of liver.
24. Enteric.
25. Pneumonia.
27. Myelitis.
28. Obesity. Œdema of legs.
30. Epilepsy.
32. Subacute rheumatism.
34. Phthisis. Pleuritic effusion.
35. Pyrexia. Hæmaturia. Hæmorrhagic pleuritic effusion.
37. Hodgkin's disease. G.P.I.
39. Pneumonia.
40. Dilated stomach.

In the Surgical Wards.

Cases under Mr. Howse.

Astley-Cooper
1. Flap wound in arm. Counter incision.
18. Crushed hand.

Job
4. Strangulated hernia. Operation.
5. Strangulated inguinal hernia. Resection of gut.
6. Growth of superior maxilla.
7. Mediastinal abscess. Operation.
8. Inflammation of frontal sinus. ? Gumma.
12. Stricture. Cock's operation.

Lydia 1. Fractured ribs.
8. Strangulated umbilical hernia. Operation.
10. Talipes equinus. Tenotomy.
15. ? Tubercular periostitis of foot.
Cot C. Fractured femur.

Cases under Mr. Lucas.

Astley-Cooper 20. Separation of upper epiphysis of femur.
Lazarus 4. Rodent ulcer.
22. Epithelioma of rectum.
Martha 16. Paresis of median nerve.

Cases under Mr. Golding-Bird.

Cornelius 5. Scalp wound. Fractured ribs.
17. Pott's fracture.
19. Compound fracture of radius and ulna.
Luke 5. Tubercular synovitis of knee.
6. Ununited fractured humerus.
9. Epithelioma of lip.
21. Inguinal hernia.
Charity 1. Ranula.
9. Torticollis.
10. Scoliosis.
16. Renal calculus.
Cot C. Hare-lip.

Cases under Mr. Jacobson.

Astley-Cooper 14. Compound comminuted fracture of tibia and fibula.
17. Fracture of humerus and punctured wound of arm.
Cornelius 2. Ruptured urethra. Separated symphysis pubis. Fragments wired.
6. Fractured femur.
12. Punctured wound of knee.
Naaman 4. Goitre (enlargement parenchymatous), right lobe removed.
7. Epithelioma of tongue and lower jaw.
8. Old tuberculous knee. Amputation.
13. Injury to knee, patella removed.
15. Double inguinal hernia. Operation.
Dorcas 5. Malignant growth of œsophagus. Gastrostomy.
11. Spinal caries.
13. Hip disease. Operation.
14. Tubercular disease of bladder. Operation. Cauterized.
18. Mastoid abscess. Operation.

Cases under Mr. Symonds.

Job 13. Tumour in rectum.
15. Ectopia vesicæ.
16. Gall-stones.
17. Syphilitic larynx.
Lydia 19. Renal calculus. Pyonephrosis. Nephrectomy.
Lydia 22. Movable kidney.
26. Femoral hernia.
Samaritan 8. Gangrene of leg. Amputation.

Cases under Mr. Lane.

Lazarus 11. Ununited fracture of humerus.
14. Epithelioma of cheek.
Martha 11. Recurrent appendicitis.
12. Adeno-chondroma of parotid gland.
Samaritan 7. Syphilitic ulcer of leg.

Cases under Mr. Dunn.

Luke 2. Old dislocation of elbow.
4. Appendical abscess.
Charity 19. Hæmaturia. ? Renal calculus.
21. Stenosis of anus.
Patience 4. Mammary abscess.
Samaritan 12. Suppurating corn. Gangrene.

Cases under Mr. Fripp.

Naaman 20. Carcinoma of pylorus. Gastro-jejunostomy.
22. Tuberculous abscess round knee. Operation.
Dorcas 20. Pereosteal sarcoma of humerus. Operation. Arm and scapula removed.
21. Appendicitis. Operation.
Patience 5. Femoral abscess.
14. Tubercular abscess of neck.

University of London.

OFFER OF COMMISSIONS IN THE ROYAL ARTILLERY AND INFANTRY.

The Secretary of State for War has made a further offer to members of the University of ten Commissions in the Royal Artillery, and ten in the Infantry. Candidates must be Graduates in Arts or Science of the University, or must have passed the Intermediate Examinations in Arts, Law, Science, or Medicine. They must be unmarried and between the ages of twenty and thirty. They will have to pass the usual medical examination. Applicants should send in their names by letter to the Registrar of the University, Burlington Gardens, W., on or before Monday, March 26th, stating which branch of the Service they prefer, or whether they are willing to serve in either of the branches named; and also the examinations they have passed, and their qualifications, including any military service, and not more than two testimonials with regard to their character and fitness to serve as officers, one testimonial being from the Head or Dean or a Professor of their College (if any).

Applicants may be required to attend at the University on a day to be named.

Guy's Hospital Dispensary Report for 1899.

OUT-PATIENTS' PRESCRIPTIONS.

THERE has been an increase of 3,048 prescriptions dispensed for out-patients compared with 1898. This increase is in the number of free and casual prescriptions. There is a decrease of 1,009 medical and 319 surgical prescriptions.

The following statement shows the number of medical, surgical, casual and free attendances of out-patients during the year 1898.

	Medical.	Surgical.	Casual.	Free.	Total.
January	2,551	1,187	1,012	749	5,499
February	2,501	1,090	999	623	5,213
March	2,831	1,212	1,013	959	6,015
April	2,130	1,006	883	804	4,823
May	2,930	1,229	842	829	5,830
June	2,514	1,303	1,160	861	5,838
July	3,491	1,360	1,943	856	7,650
August	2,857	1,381	2,325	928	7,491
September	2,655	1,321	1,549	1,024	6,549
October	3,512	1,276	1,007	974	6,769
November	3,981	1,283	1,057	984	7,305
December	2,319	918	833	852	4,922
	34,272	14,566	14,623	10,443	73,904

	1899		1898
Medical	34,272	...	35,281
Surgical	14,566	...	14,942
Casual	14,623	...	13,291
Free	10,443	...	7,342
	73,904	...	70,856

Payments—1899, £862 12s. 8d.
1898, £874 9s. 9d.

COST OF SURGICAL DRESSINGS.

	1899. £ s. d.	1898. £ s. d.
Bandage Cloth	28 12 11	17 3 9
Bandages—Dispensary	74 4 2	63 16 0
Wards	532 9 0	518 16 0
Compressed Moss	0 11 6	—
Cellulose Wadding	2 12 6	3 4 0
Felt Plaster	4 19 6	9 5 0
Gutta Percha Tissue	78 17 1	68 2 2
Gauze—Grey	60 19 7	45 1 2
Iodoform	120 10 1	142 2 8
Carbolic	10 12 6	10 17 6
Sal Alembroth	35 11 0	43 10 0
Cyanide	3 4 7	11 10 0
Gamgee Tissue	9 6 1	5 7 4
Lint	318 5 4	311 11 5
Boric Lint	56 18 8	35 11 8
Protective Silk	4 3 4	2 2 9
Robinson's Dressing	4 5 9	4 5 9
Carried Forward	£1,346 3 7	£1,292 7 2
Brought Forward	1,346 3 7	1,292 7 2
Spongio-Piline	—	1 4 0
Tow	19 0 0	24 0 0
Carbolized Tow	5 0 0	6 2 0
Wool—Absorbent	118 19 8	101 1 8
Grey	38 19 4	36 11 6
Sal Alembroth	67 17 4	75 11 8
Salicylic	69 5 9	51 17 8
Wood	4 13 4	2 16 0
Iodoform	—	1 1 0
	£1,669 19 0	£1,592 12 8

N.B.—The average number of beds in daily occupation was 423·6 in 1898, and 458·2 in 1899, being an increase of 34·6 beds.

COST OF ANTISEPTICS.

	1899. £ s. d.	1898. £ s. d.
Creolin	6 5 7	4 12 1
Creolin Dusting Powder	—	0 12 3
Formaldehyde	5 13 8	3 5 2
Iodoform	56 14 0	77 14 4
Lysol	176 16 1	101 8 1
Acid—Boric	23 0 6	22 1 11
Carbolic	51 16 8	76 6 8
Hyd. Perchlor.	7 14 4	5 12 2
Ol. Eucalypti	1 8 11	2 5 0
Salol	3 1 7	1 11 0
Resorcin	3 5 0	0 19 9
Rape Oil (for Carbolic Oil)	10 0 0	10 0 0
Sanitas	1 10 0	2 4 0
Chinosol	8 2 0	5 4 6
	£355 8 0	£316 14 8

The largest item of increase is Lysol (£75 8s.). The use of this antiseptic began in 1895 (£1 10s.), it increased in 1896 to £61 3s. 6d., in 1897 to £66 9s. 1d., in 1898 to £101 8s. 1d., and in 1899 to £176 16s. 1d. It was supposed that Lysol would replace Carbolic Acid, but the decreased cost of the latter is not proportionate to the increase of the former.

Carbolic Acid cost in 1895 £98, in 1896 £114 6s. 8d., in 1897 £79 6s. 8d., in 1898 £76 6s. 8d. and in 1899 £51 16s. 8d.

COST OF ANÆSTHETICS.

	1899. £ s. d.	1898. £ s. d.
Ether	44 9 7	52 7 11
Alcohol	21 6 10	16 0 1
Chloroform	42 9 1	35 5 4
Cocaine Hydrochloride	9 1 2	13 16 6
Nitrous Oxide Gas	40 15 10	35 0 6
Ethyl Chloride	9 10 6	3 19 0
	£167 13 0	£156 10 3

LIST OF DRUGS DECREASED IN COST.

(Above £2.)	£	s.	d.
Ammon. Bromidum	2	9	4
Ammon. Benzoas	2	4	4
Aq. Aurantii Floris	2	3	10
Antistreptococcic Serum	4	10	0
Ext. Malti	25	15	0
Felt Plaster	4	5	6
Guaiacol Carb.	2	18	4
Liq. Pancreatis	5	11	2
Cod Liver Oil	35	11	9
Phenazonum	6	3	2
Rad. Gentian.	6	6	1
Sugar Crystals	4	13	4
Succus Limonis	3	1	6
Syr. Hypophosph. Co.	4	15	3

LIST OF DRUGS INCREASED IN COST.

(Above £2.)	£	s.	d.
Ext. Nucis Vom.	3	8	7
Ferri et Quin. Cit.	16	19	3
Folia Sennæ	2	7	7
Formaldehyde	2	8	6
Homatropin. Hyd.	7	5	6
Hypnol	10	0	0
Acid. Hydrobrom. Dil.	3	7	8
Atropin. Sulphas.	2	5	9
Bismuthi Carb.	5	5	0
Camphor	10	13	4
Codeina	4	13	3
Creosote	3	4	8
Ext. Cascar. Sag.	4	4	0
Ol. Santal. Flav.	6	15	11
Ol. Olivæ	6	17	9
Musk	12	15	0
Potass. Iodid.	23	16	0
Pulv. Glycyrrhizæ	2	19	2
Rad. Rhei	8	14	7
Rad. Senegæ	2	5	4
Sodii Salicylas	2	14	7
Spt. Æther, Nit.	3	14	6
Spt. Ammon. Aromat.	3	2	1
Spt. Vini Rect.	50	12	6
Syr. Calcii Lactophosphatis	6	10	8
Turpentine	10	0	7

The most notable increase is that of Ferri et Quin. Cit. £16 9s. 3d. A new Guy's Hospital Pharmacopœia came into use in the early part of the year. The formula Mist. Ferri et Quininæ, which was not in previous pharmacopœias, found universal favour, and is now largely ordered. Cost of Ferri et Quin. Cit, in 1896, £1 16s. 9d., in 1897, £1 17s. 8d.; in 1898, £3 13s. 4d.; and in 1899, £20 12s. 9d.

The increase in the cost of Radix Rhei, and also of Spirit of Wine, is due to the new Pharmacopœia. A supply of Potassium Iodide was obtained towards the end of the year, which accounts for the increase in this article. Musk appears to be now established as a regular therapeutic agent. The increase last year was £12 5s. 0d. Cost of Musk in 1895, £3 0s. 0d.; in 1896, £3 0s. 0d.; in 1897, £9 10s. 2d.; in 1898, £12 5s. 0d.; and in 1899, £24 10s. 0d.

THE PHARMACEUTICAL LABORATORY.

The work of this department shows an increase (12,442) in the number of syphons of Soda water and Lemonade made compared with the year 1898. Nurses have been supplied with Soda water and Lemonade since last September.

	1899.	1898.
Number of Syphons filled	38,526	26,084
Cost of Carbonic Acid Gas	£6 1s. 2d.	£6 12s. 9d.

The cost of Carbonic Acid Gas in 1899 has been 3/9 per cylinder against 5/- in 1898. The quantity of Ointment and Pills made in 1899 is somewhat smaller than that of 1898. The increase in syrups is due to the larger quantity of Syrup of Lemons required for Lemonade. There is an increase in Tinctures and Strapping. The preparation of concentrated liquors commenced with the new Pharmacopœia.

	1899.	1898.
Various Pills	448,000	588,300
Strapping Plaster	11,536 yds.	10,300 yds
Lemon Syrup	610 galls.	--
Simple Syrup	206 galls.	600 galls.
Various Ointments	4,796 lbs.	5,671 lbs.
Various Tinctures	402 galls.	322 galls.
Concentrated Liquors	40 galls.	—

(Signed) H. COLLIER,
Head Dispenser.

Guy's Hospital,
20th February, 1900.

Royal College of Physicians.

Lectures of the present year will be delivered at the College, Pall Mall East, on each of the following Tuesdays and Thursdays, at 5 o'clock:—

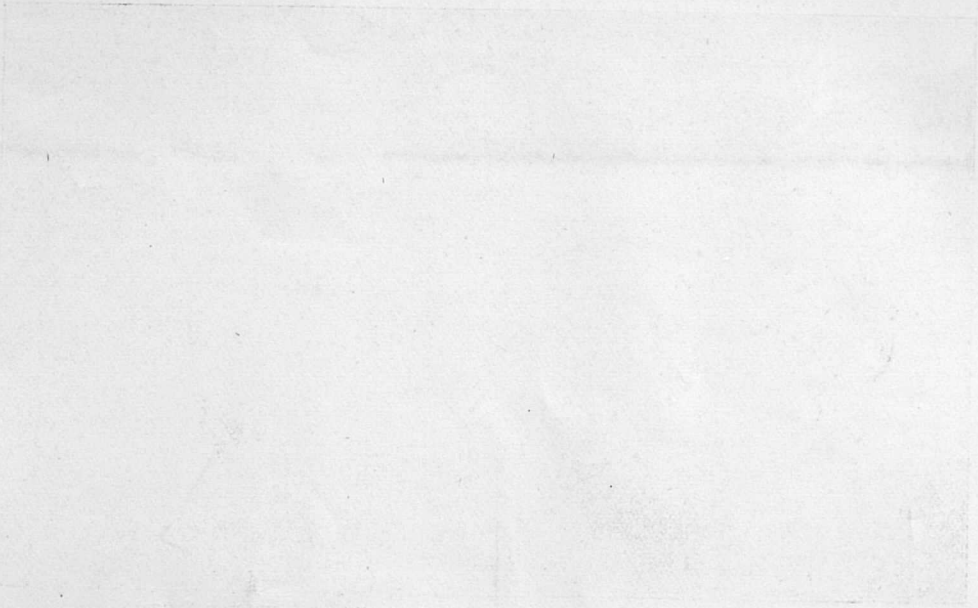
Coulstonian Lectures.—Dr. P. Horton-Smith, March 20th, 22nd, 27th. "The Typhoid Bacillus and Typhoid Fever."

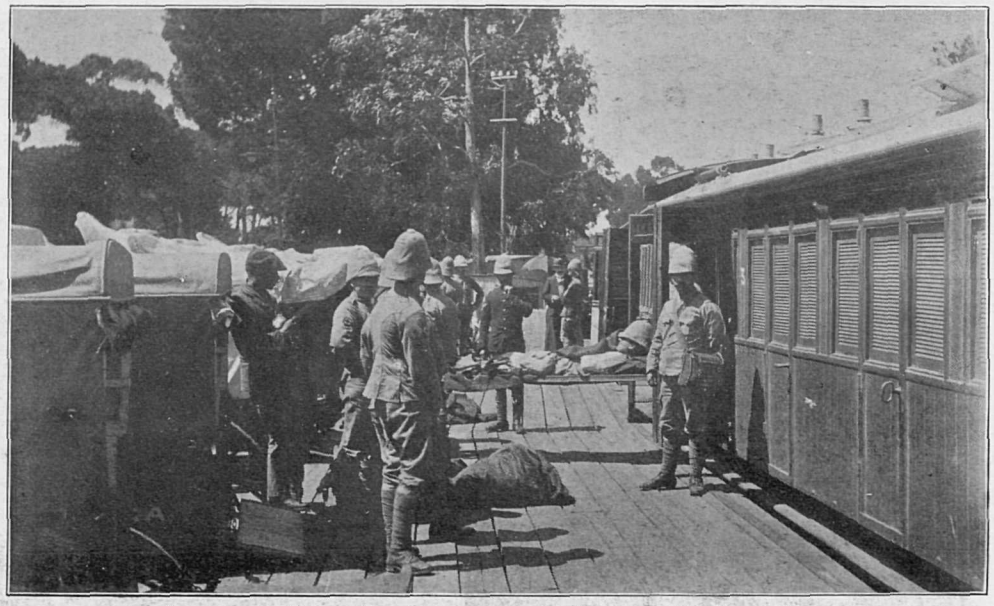
Lumleian Lectures.—Dr. W. B. Cheadle, March 29th, April 3rd, 5th. "Some Cirrhoses of the Liver."

By order of the President,
WILLIAM FLEMING, Bedell.

Guy's Hospital Colonial Club.

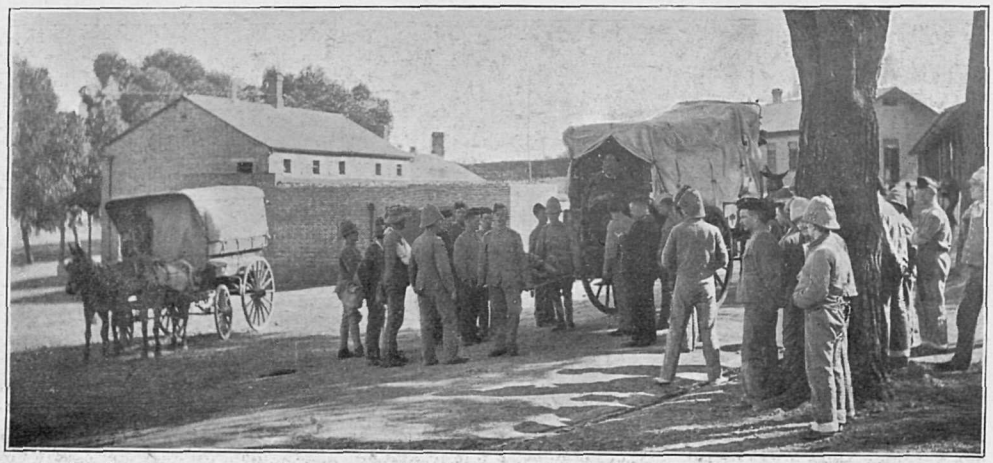
The third annual dinner of this club will be held at the Holborn Restaurant on Tuesday evening, 20th inst., at 7.45 p.m., when Mr. Symonds will take the chair. All Guy's men, past or present, who have been identified with India or the Colonies are *ipso facto* members of the club, and welcome at the dinner. Those who intend to be present are requested to inform the secretary without delay. F. G. GIBSON, Hon. Sec.





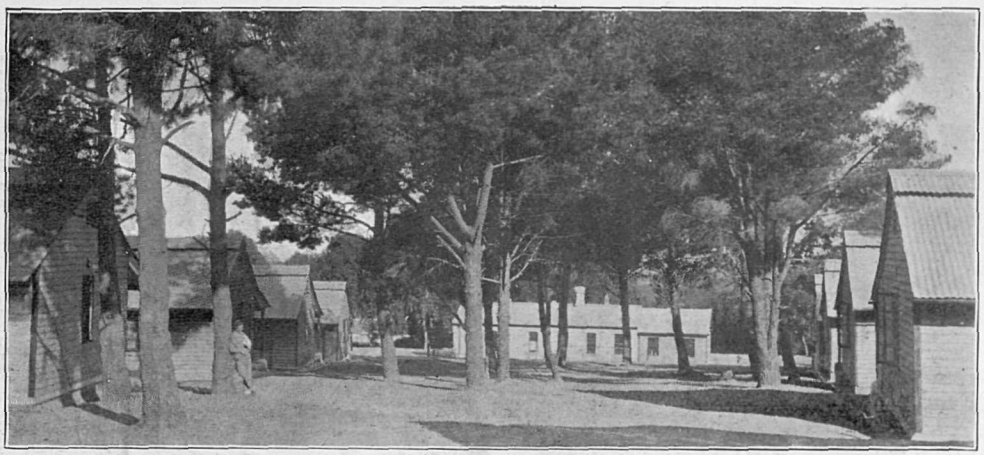
1.—AMBULANCE TRAIN NO. 3 DRAWN UP IN SIDING AT WYNBERG STATION.

2.—STATION-YARD AT WYNBERG, ON ARRIVAL OF A HOSPITAL-TRAIN.



3.—ARRIVAL OF THE AMBULANCE-WAGGONS AT NO. 1 GENERAL HOSPITAL, WYNBERG.

Photographs by J. E. BRUTON CAPE TOWN.



4.—Typical view of Huts in No. 1 General Hospital.

5.—Interior view of a Hut.

6.—No. 2 General Hospital, Wynberg, under canvas.

Passim.

May we again call attention to the subscription list which we have opened for the supply of comforts to the R.A.M.C.? A special feature in the administration of this fund, is the determination to extend the benefits to the native stretcher-bearers, whose bravery and devotion to duty have been so marked. The Gazette will receive and acknowledge subscriptions of half-a-crown and upwards; the Librarian will receive shillings in any number. The smallness of the sum asked individually, places it within the bounds of everybody's purse, and the excellence of the object should recommend it to everybody's consideration. All of us have subscribed to one or other of the many praiseworthy funds already extant, but this should not prevent a liberal response to an appeal which is peculiarly applicable to the medical profession.

It is almost impossible to realize that the present open space at the end of the colonnade was, a few days ago, a busy accident ward. The work of destruction and subsequent construction has been pushed on with really wonderful rapidity and already much of the new concrete flooring has been laid in the "back" ward. If one may judge by a cursory inspection of the old wooden joists which have given place to the modern H girders, renovation has commenced none too soon; the probability is, however, that these old timbers, hewn and laid long before jerry building was a recognised art, have plenty of life in them yet, and owe their time-worn appearance merely to the ravages of generations of rats. Dressers of a dozen years ago, will recognise with pain that the imperative needs of the hospital have led to the extinction of the ground floor "dresser's bedroom"—the pantry of the present generation of surgeons' dressers—which has merged temporarily at least, into the general space occupied by Astley-Cooper ward.

Another matter on which the Works Department deserves congratulation is the renovation of the entrance gates of the hospital. The scroll work and arms which surmounted the gates have been removed and replaced by a handsome piece of ironwork, in which as much as possible of the original material has been utilized. No doubt, from the archæologist's point of view such renovation is in the last degree reprehensible, but that large percentage which lacks any great reverence for antiquities will rejoice in the very obvious improvement that has been made in the appearance of the gates. And the antiquary may take comfort that his æsthetic sense has not been shocked by any modern crudity of copper and iron. The present gateway retains all the stately beauty of old-time scroll-work.

In another column will be found a notice issued by the War Office, in which graduates and intermediates of the University of London are offered twenty commissions in the artillery and line. This, we believe, is only one of several notices which have been sent to the various Universities: in the University of Cambridge over seventy, in the University of Oxford over eighty commissions are offered to graduates. The wisdom of this course is open to criticism. Apart from the solid objection that it takes a lot of training to make a gunner, and that even a line subaltern has to be schooled in a manner scarcely realized by the civilian, there is the whole question of disparity of age which must obtain between officers commissioned in the ordinary course of events from Woolwich and Sandhurst, and those appointed from the Universities. The qualification, a degree in arts or science, or the pass certificate of the various intermediate examinations, practically prevents a man from receiving his commission until he is several years senior to the Sandhurst cadet.

If, for example, we consider the case of the average man doing the London degree in medicine, we may take it that he would leave school at seventeen or eighteen years of age. Allowing a year for his matriculation—no excessive allowance when he leaves school at seventeen—and another year for the Preliminary Scientific, we have him at nineteen years before he commences medical work proper. Two more years are required before the Inter. M.B. can be passed, and by this time the candidate has reached his majority. Now, a Woolwich cadet, entering the service under equally favourable circumstances as regards time would find himself with a commission at eighteen, three years junior to his considerably less technically educated fellow from an university. And in their subsequent professional career, the university man would, of course, labour under the same age disadvantage with which he started, and would run the involved risk of retirement before he had attained a position in the service.

Another argument of quite a different nature may be briefly expressed in the remark that the man frequently most fitted by nature and inclination to a combatant post in the service, is the very man who has not succeeded in passing his Inter. M.B., who, in fact, probably never would pass this examination.

The Medical School announces for competition a Travelling Dental Scholarship, value one hundred pounds, open to gentlemen holding the diploma of L.D.S. of the Royal College of Surgeons of England; such gentlemen to have received their professional education at Guy's Hospital. Applications must reach the Medical School Office, on or before June 1st, 1900, and should be addressed to the Dean, from whom any further particulars may be obtained. There is no mention of any age limit in the particulars we have received, so we take it the scholarship is open to any qualified Guy's dental student.

The Volunteering Movement made an appreciable advance on Wednesday, when a meeting "of those interested in volunteering," was held in the physiological theatre. Mr. Cosmo Bonsor was announced to take the chair, but at the last moment he was prevented by urgent political business from attending. It was a great disappointment to the meeting, more especially as Mr. Bonsor takes a very keen interest in everything connected with the volunteer forces. However, he supplied a very able substitute in Colonel Lucas, Transport Officer of the South London Brigade, whose long connection with the hospital, both as captain of the hospital company in the 20th Middlesex R.V., and as a governor, made him pre-eminently fitted to take the chair at such a meeting. It goes without saying that the meeting was enthusiastic and—rash. It allowed itself to float with Mr. Milson, into the dreamy fairy-lands of martial bliss, where the maximum efficiency is obtained with the minimum expenditure of time and money, and almost resented the sharp tugs by which sundry speakers strove to drag it down to the prosaic level of facts and figures. The final outcome of the meeting was the appointment of a committee of ways and means, and an adjournment until this committee should have prepared and presented a report. About a hundred men were present.

It was only four weeks ago to-day that a crowd of nurses and men bade farewell to the last of the Yeomanry Hospital. And yet, such have been the changes in the course of events in South Africa, the time seems infinitely more remote; and when one recalls the crowd of fluttering femininity and stolid males changing as the train left the platform, into one wildly excited, cheering mob, with wet eyes and lumpy throats, the memory seems to travel back over many months and even years. Already in this war we have experienced the reverse of the shield. The telegram which announced the death of poor Onraët at Ladysmith, cast a gloom over the hospital, which was reflected on the face of everyone. He had only left us last year; all the senior men knew him, and most had reckoned him as a friend. And then the bitter irony, of the unarmed surgeon, whose only mission was to save life, killed by a chance shot, made the loss still harder to bear.

One could not help being struck by the excuses made by the sporting papers for Richmond while accounting for their defeat at our hands last Saturday; we saw no reference to an equal shortage in our own team. No fewer than five of our regular players were absent, and their places were filled by men from the second fifteen, and by some boys of our "old brigade" who have been practically on the shelf for a season or more. At a time like the present, when so many of our athletes are busy in Africa, clubs like Blackheath and Richmond, which practically depend on a floating population, must necessarily be at a disadvantage as compared with those which depend on a smaller but more constant number of players.

This afternoon our Second Fifteen meets Sutton in the semi-final round of the Surrey Cup competition. We wish their energetic captain, M. A. Collins, and his men every success, and hope they will do their utmost to regarnish the smoking-room, which is now deplorably lacking in silver plate. As the match is to be played at Honor Oak Park, the second should be urged on by a big attendance of supporters.

There could be no two opinions on the success of the "Smoker" last Saturday. An excellent programme had been provided, and the entertainment went with a swing from start to finish. An additional factor in the enjoyment of the evening was the presence of a large number of the Staff, who for the nonce forgot their gravity and entered into the spirit of the concert with the wholeheartedness of buoyant youth. Thus in one season, two most successful smoking-concerts have been given; and this

occasions wonder that for some years this form of amusement has been allowed to drop through sheer hospital inertia. Possibly we now see the commencement of a new era—era, not century—with a revived interest in the social side of our life, but it remains with the younger men now at the hospital to convert the possibility into a probability, and the probability into a certainty. Moreover, it is but scant courtesy to reward the men who have the trouble and bother of arranging a concert with an empty room and a lack of musical support.

We have been accustomed to pat ourselves on the back in the possession of an adjunct to our medical wards which is almost unique in London. It is true that the Clinical Laboratory is very small, and only imperfectly fitted, but it is nevertheless an inestimable boon to the medical ward clerk and clinical assistant. So indispensable does it now seem to us, that one is tempted to ask whether its scope could not be more usefully extended. Such, of course, would be impossible in the present quarters, but if a larger room were provided with the requisite apparatus, including microscopes and microtomes, of a clinical laboratory, and placed under the direct control of say, the Chemical Pathologist, much good might result in every direction. No one would advocate any additions to the present room under the present system; it would be mere waste of material to provide instruments of precision without at the same time assuring their proper and legitimate use by the presence of one of the Junior Staff. The Medical Registrar is nominally responsible for the Laboratory, but the very nature of his duties makes it impossible for him to be present in the mornings, when the room is chiefly in use. We certainly think that some alteration in the existing condition of things is worthy of consideration.

The Annual Report and Statement of Accounts for the year 1899 of the Medical Defence Union contains much that is instructive to the general practitioner. Apart from inner light on certain *causes célèbres*, in which this Union appears as the hand which directs the sword of justice, a rough analysis of smaller matters investigated by the Union at the request of members, shews the extraordinary number of charges of malpraxis which is brought against medical men. In every case the result is the same, "letter sent stating Union would defend," and then the significant words, "action collapsed." In these alone, without taking into consideration the numberless cases of "covering" and kindred misdemeanours which are exposed, the Union is deserving of the support of the medical profession. Anything which lessens the liability to attack by ignorant men and hysterical women, must merit the thanks and support of the practitioner.

The Debating Society has secured permission to use the Court Room on the occasion of the annual "Ladies' Night," Saturday, March 24th. The agenda paper reads as follows: "(1) Minutes. (2) Private business. (3) "That in the opinion of this house the Government should make some strenuous attempt to prevent the wide-spread abuse of alcohol.'" The inclusion of the second item is in accordance with the view expressed in these columns, that private business always clears the air for serious debate, and that the general tone and quality of subsequent proceedings are invariably raised when the house has previously indulged in a little personal recrimination. However, we hope on this occasion at least, that members will refrain from indulging in the pastime of secretary baiting, if only for the sake of a little variety. The question of the evening is so deliciously vague and so pregnant with possibilities that a good discussion must result; the choice of speakers, too, has been happy, for both Mr. Kitchin and Mr. Brydone are past masters of plausibility. With Dr. Pavy in the chair, and a good number of visitors—who may speak but not vote—the evening will be assuredly a great success.

In a very short time operations will commence on the front surgery with the object of enlarging it to meet the present requirements of casualty work. An inspection of the plans shows that the new building will leave little to be desired. In the first place, the front wall of the surgery will be pushed forward for about fourteen feet, thus bringing the right wing of the hospital to the level of the main entrance. The present dressers' room will be thrown into the available space, and the whole apportioned out into two surgeries, with plenty of examination rooms. Lavatory accommodation for patients is to be provided, and the isolation ward freshly located and placed in direct communication with the surgery. The projecting portion of the surgery will form a gallery for Lazarus ward, and above this, too, will be placed another gallery for Naaman, the whole supported on stone columns. The new front preserves the original character

of the architecture, and save in the addition of the galleries above mentioned will in no wise differ from the familiar face of "Guy's House."

Last night was held an assault-at-arms in connection with the Pavy Gymnasium. Besides the finals of the boxing and fencing competitions, and the gymnastic display, there was a most interesting exhibition of Elizabethan sword play, under the direction of Captain Hutton. We hope in our next issue to publish a full account of the proceedings.

Guy's Hospital Dental School.

TRAVELLING SCHOLARSHIP.

A Travelling Scholarship of the value of £100 has been founded.

The first award will be made in June, 1900.

The Scholarship is open to Licentiates of Dental Surgery of the Royal College of Surgeons of England who have been educated at Guy's Hospital Dental School.

Names of applicants for the Scholarship must be sent to the Dean of Guy's Hospital, on or before June 1st, 1900, from whom also further particulars may be obtained.

Guy's Hospital, March, 1900.

Royal Army Medical Corps.

"COMFORTS FUND."

The following subscriptions have been received:—

	£	s.	d.
Elliot Blake, Dr. H.	0	2	6
Evans, Dr. J. H.	0	2	6
Handley, Dr. W. S.	0	2	6
Holloway, Dr. S. F.	0	7	6
Manning, Dr. T. Davys	0	2	6
Sadler, Dr. H. G.	0	2	6
Taylor, Surgeon-General E.	0	2	6
Turner, H. S., Esq.	0	1	0
Turner, T., Esq.	0	1	0
Umney, R., Esq.	0	2	6
Williams, Fleet-Surgeon E. H.	0	2	6
Williams, Dr. R. E.	0	2	6

Additions to List of Guy's Men Serving in South Africa.

Orderlies to Capt. Fry, R.A.M.C., 9th Battalion Imperial Yeomanry—A. Moon, C. B. Sells.

Orderly to Capt. Hadley, R.A.M.C., Duke of Cambridge's Own Imperial Yeomanry—G. T. Wrench.

Field-Dressers to Capt. Viddler, 14th Battalion Imperial Yeomanry—L. J. Hughes, R. Willan.

Imperial Yeomanry—Troopers C. Watson-Smyth and E. J. Malin.

Surgeon to Imperial Yeomanry Field Hospital—William Sheen, M.D., M.S., F.R.C.S.

Acting Civil Surgeon, No. 9 General Hospital, Cape Colony—H. A. Bryant.

With the Army Medical Corps in South Africa.

(By Our Special Correspondent.)

PHOTOGRAPHS.

1.—Ambulance train No. 3 drawn up in siding at Wynberg station. Ambulance waggons on left drawn up in station-yard and backed up to platform, which, being about three feet high, is nearly level with the floor of the waggons. In the second waggon the tail-piece has been opened backwards on its hinges, and rests on the platform. The stretcher is run bodily into the waggon on castor wheels of its own, and occupies one half of its floor, the patient's head being in front. The patients are transferred directly to the stretcher inside the train; and remain on the same stretcher until they reach their bed in the hospital. Such of their equipment as they have with them accompanies them on the stretcher—haversack, for instance, belt, valise, and water-bottle, as in this photograph—and is removed to the pack-store of the hospital the same or the next day. The case here shown is one of fractured humerus, contracted at Magersfontein.

2.—Station-yard at Wynberg, on arrival of a hospital-train; looking the opposite way to the first photograph. Train and ambulance-waggons on left; private houses and crowd on right. The two vehicles in centre of view are typical Cape-carts, something like dog-carts, only with the back seat facing forwards, and with a large square hood of white canvas. The waggons are drawn by two mules and driven by a coloured man, by whose side there is room for two "sitting-up cases." They walk the mile uphill to the hospital very steadily at a slow march.

3.—Arrival of the ambulance-waggons at No. 1 General Hospital, Wynberg; where they are received by a detachment of orderlies of the R.A.M.C. under the burly staff-sergeant who is seen dressed in cloth and taking notes. At his direction the lying-down cases are carried and the rest assisted up to their respective huts. The building on the left is the P.M.O.'s offices, with a sentry patrolling up and down under the verandah or *stoep;* while beyond this in the centre is a flag-staff which usually flies the Red Cross flag and the Union Jack. The huts run up the hill to our right; and the front of the lowest with its *stoep* is seen on the right of the photograph.

4.—Typical view of huts in No. 1 General Hospital, looking down the hill to the space shown in the last photograph where the waggons are discharged. Four huts of the medical division (B) are seen on the right; and four of the surgical (A) on the left. The trees are "cluster-pines" which cover the ground with needles and cones.

5.—Interior view of a hut; the daily round of the civil-surgeon, making up diet-sheets, a soulless and almost

useless occupation. The sister, who comes from the London hospital, is finishing off a dressing. The beds are iron beds, folding up in the middle, with wire mattresses, all brought from England as part of the hospital equipment. The feet of the beds are often rested in old cigarette-tins filled with kerosene, so as to repel the enemy and the invader, who abounds in the wood-work of the huts and cannot be dislodged from his position. Over each bed now hangs a mosquito-net provided by the Good Hope Society for keeping off flies. It will be noticed that the wards are supplied both with oil and electric light; that there is a stove which at present is never used, and that there is plenty of light and ventilation during the daytime with windows right along either side of the ward. Each ward (or half-hut) contains twelve to fourteen beds. On the left in the foreground are the ends of two beds containing two cases of comminuted fracture of the femur, treated by extension, the weight being a bag of earth.

6.—No. 2 General Hospital, Wynberg, under canvas; two blocks each containing row upon row of marquees, six in each row. This view looks along the outside row of one block to the second block in the left distance. Each marquee is floored with boards or tarpaulin and contains six beds and lockers, a table and two forms, with a possibility of two more beds if necessary. The whole is most comfortable; and as the sides of the tent can be looped up during the middle part of the day, the heat is not intolerable. The hospital is pitched in long grass and so there is comparatively little dust to give trouble. The men in the foreground include both R.A.M.C. orderlies and patients, patients in khâki, patients in their soft blue hospital kit with white lining and red neck-scarves, patients in helmets, patients in slouch hats, patients with beards, as they come from the front, and patients shaved, as when a visitor is coming to see them. Further off on the left are a few of the native boys, who do the cleaning and scavenging about the camp.

Obituary.

Lieut. H. Bernard-Onraet.
R.A.M.C.

It is with very great regret that we record the untimely death of Lieut. H. Bernard-Onraët, R.A.M.C., who was killed at the relief of Ladysmith on February 27th.

Educated at Cranleigh School, Bernard-Onraët commenced his professional training at Guy's in April, 1892, and qualified M.R.C.S., L.R.C.P., in 1898. He entered the Service in the following year, and after a probationary period at Netley, was ordered to South Africa.

His loss is greatly mourned by all who knew him at the hospital, where his genial personality and his keen sporting interest in athletics, more especially in the work of the Association Football Club, of which he was secretary, alike gained him many friendships. By his death, Guy's has lost a true son, and the Service a splendid officer.

Mr J. C. Williams.

We regret to announce the death of Mr. J. C. Williams, of Middlesboro'-on-Tees. Mr. Williams was primarily an Edinburgh University man, where he gained the silver medal in Anatomy, and subsequently a demonstratorship in the same subject at the Royal College of Surgeons. Graduating M.B., C.M., in 1891, he spent a few years as surgeon on various liners, and on his return to England took up a post-graduate course at this hospital, from which he passed the M.R.C.S. Eng., L.R.C.P. Lond., in 1897. He then commenced practice at Middlesboro'-on-Tees, where he rapidly established a high professional reputation, and a large circle of friends through his kind, thoroughly upright and honourable disposition.

At the time of his death, from pneumonia contracted at his father's funeral, Mr. Williams was holding the office of Public Vaccinator for the Middlesboro' District. His loss will be mourned by a great number of professional and personal friends.

"Religio Medici."

Lecture by Mr. George Russell.
On Monday, February 12th, in the Chapel of the Hospital.

REVERENCE.

The lecturer, finding the highest sanction for the duty of reverence in the example of Christ, insisted upon its importance and necessity, and then proceeded to point out in succession six objects that demand our reverence.

1. The first of these objects is God—Two main views in regard to God may be distinguished: the one represented by Newman's words,—"To me there are two and only two absolutely and luminously self-evident beings, myself and my Creator;" the other by the words, "Nature suspects the God she cannot prove." But to whichever view we incline the duty of reverence to God is equally imperative. Carlyle speaks of it as of paramount obligation, and the lecturer quoted Gladstone to the same effect.

2. The lecturer next pointed out the duty of self-reverence, and referred to two forms which it assumes—Purity and honour, including under the latter the refusal to regard humble duties as common or unclean, and the intention to undertake nothing which would not give free play to the best moral instincts.

3. The profession of his audience—the medical—next claimed the lecturer's notice as an object of reverence on two grounds. (i.) As a noble and conspicuous field of intellectual exercise. (ii.) As a ministry of human

service; it should never be merely a means of money-getting, nor of trading upon the moral and intellectual weakness of patients.

4. Humanity is a fourth object of reverence. "You are the sworn servants of humanity, and you must learn to cherish amid surroundings, however difficult, your reverence for that human nature which our Lord took." The story of Muretus illustrates the standpoint we should adopt in relation to the human body. *Fiat experimentum in corpore vili*, said the surgeons of his day: in rebuke the scholar incognito exclaims, *vile putasnè corpus pro quo Christus non est dedignatus mori?*

5. Knowledge—hardly-gained, well-earned, well-established knowledge, is another object of reverence.—"Be sure of your facts," wrote Sir Russell Reynolds, "and then do not fear them. What is true is of God, and you will find its real bearing on other things that are true, if you work and wait."

6. The lecturer then passed on to the sixth object of reverence,—the *Unknown*. "The greater our knowledge of fact," he said, "the more ready are we to admit the existence of things which lie upon or beyond the borderline of that mysterious region where soul infringes upon body." After illustrating this by a second quotation from Sir R. Reynolds, he passed on to the conclusion of his lecture.—"This leads me back to the point from which I started—Reverence for God. We hear people speak about God in a variety of synonyms. Matthew Arnold's phrase was, "a stream of tendency, a Power not ourselves that makes for righteousness." In many pulpits He is spoken of as "The Supreme Intelligence;" while one well-known preacher is never so happy as when he is using the expression "the Power that lies behind phenomena." Now, I have not a word to say against these phrases except that they do not advance us one syllable beyond that short word GOD, they do not help us to apprehend more vividly that great unseen, living, operating, conscious, and Fatherly Being Who is the object of our reverence—

"And He it is Who brought us hither
And holds the keys of whence and whither."

The two concluding lectures of the series will be given by the Rev. Canons Gore and Newbolt, on March 5th and 26th respectively.

Papers by Guy's Men.

Two Cases of Colectomy. By F. T. Paul, F.R.C.S.—*British Medical Journal*, 3rd February.

The Ingleby Lecture.—The Treatment of Eczema. By Robert M. Simon, M.D., F.R.C.P.—*Birmingham Medical Review* for February.

An Address on Medical Practice in European Countries. By Thomas Kilner Clarke, M.A., M.D.—*British Medical Journal*, 17th February.

The War in Africa.

(From a Special Correspondent.)

H.M. Sick Transport, Spartan,
Durban, Natal,
February 10th, 1900.

So much has been written about life on transports, that the subject is by this time worn almost threadbare. The hospital transport, Spartan, has been well discussed, but a short account of her administration may not be uninteresting. In the first place, it may not be generally known that this is the first time that a hospital ship, or indeed any ship carrying troops, has been administered by a medical officer in the army. Previously, the command has been in the hands of a combatant officer. The granting of substantive rank to officers of the Royal Army Medical Corps, has done away with this relic of mediæval absurdity. The idea that an officer of the medical branch of the service was incapable of taking command of troops, is the result of a fossilization of thought which unfortunately permeates most of the other branches of the service. It is forgotten that half a battalion of Guards was commanded by a medical officer throughout the greater part of the battle of Inkerman. It is also overlooked that the training and education of a medical officer is far more thorough, more scientific, and tends to a greater degree of accuracy of thought than any other branch of the service. Until now, the hospital troopships from India have been under the control of a combatant officer, in many cases junior to the medical officer in charge of the sick troops. But now, with the recognition of the true status of the medical branch of the service, this has all been changed.

The internal arrangements of the Spartan are well-known, but I will briefly recapitulate them. She has accommodation for sixty-seven severe cases, and sixty-four convalescents. There are three large wards, a small ward of five cots for officers, and a smaller ward of two cots for fracture cases. The first of the three large wards contains nineteen cots, the second fifteen, the third twenty-six. The accommodation for convalescent cases is distributed throughout the ship.

A well-fitted operating theatre is placed amidships. There is a liberal supply of every kind of surgical instruments, dressings and surgical accessories, together with a well-stocked dispensary.

The personnel consists of the Principal Medical Officer, Major Woodhouse, R.A.M.C., who hails from the school of Guy's dearest enemy, St. Thomas's Hospital, and to whose administrative genius so many of us in Natal owe so much. There are two civil surgeons, three sisters of the Army Nursing Service, and twenty-one non-commissioned officers and men of the R.A.M.C.

The civil surgeon is on duty as orderly medical officer every other day. The routine of duty of orderly medical officer for the day is as follows:—At 8.30 a.m. the meat, fish, fowls, etc., for the patients' dinners are inspected

in the butcher's pantry and carefully scrutinized and examined as to quality, freshness and quantity, etc. At 9.30 a.m. the quarters of the men of the R.A.M.C. mess-utensils, tables and decks are inspected, the orderly for the day being responsible for their cleanliness and tidiness. At 10 a.m. the wards are visited by the medical officer under whose charge they are, all dressings are done and diets and medicines ordered. At 12.30 p.m. the cooked dinners for sick and wounded are inspected by the orderly medical officer for the day, in the cook's galley, before being sent to the patients. The duty of the medical officer ceases at 1 o'clock in his particular ward, under ordinary circumstances, and in any emergency the orderly medical officer for the day is sent for, whether it be his own case or not, and he is responsible for it. The responsibility of the medical officer in charge of the case ceases after the morning visit has been paid, this visit being held to finish at 1 p.m. Of course, he has the right to attend the case if he wish, but he is in no wise responsible for it, this resting upon the orderly medical officer for the day. At 12.45 noon the wards are again visited by the orderly medical officer for the day, to enquire if there are any complaints about the dinners. If a complaint is made it is at once investigated and put right. At 1 p.m. the mess of the R.A.M.C. is visited in the same way. The orderly medical officer for the day makes a round of all the wards at sunset, and again at 10 p.m., his duty lasting twenty-four hours from 9.30 a.m.

The Spartan is a "Sick Transport"; she is not a "Hospital Ship." The difference lies in the technical meaning of the words employed. As a "Sick Transport" she is on "lines of communication," and is not a Base Hospital. She is placed under orders of the P.M.O. of the Natal Field Force for the time being, her headquarters being the headquarters of the British Army in South Africa, at Capetown.

The work of the Spartan is to tranship the sick and wounded of the Natal Field Force from Durban, Port Natal, to the Base Hospitals at Wynberg and Rondebosch, Capetown. She has already performed three journeys, taking wounded after the battles of Elandslaagte, Colenso and Spion Kop. Of these three journeys I will endeavour to give a description in my next letter, and if possible a description also of the different interesting phases which Durban has gone through since we arrived here early in November.

S. E. D.

Guy's Hospital Students' Club.

The Annual General Meeting of the Students' Club will be held on Friday, March 30th, 1900, at 4 p.m., Dr. Pye-Smith in the chair. Business: Election of Student Representatives on the Club Committee.

Novelties.

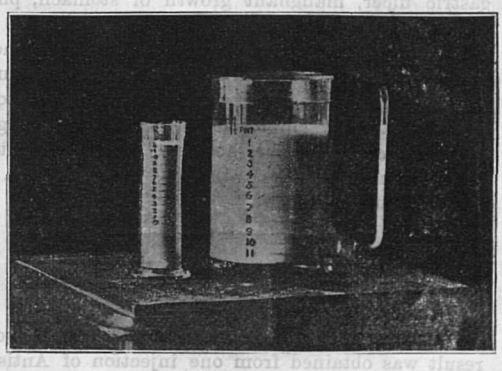
A NEW MILK HUMANISER.

We have recently had brought under our notice a new, simple and ingenious piece of apparatus for humanising cow's milk. It is the invention of Dr. H. J. Blackler, of Redhill, an old Guy's man.

It is a well-known fact that babies who from any cause cannot be fed by the breast, may be very difficult to rear by hand, the difficulty being caused by the inherent difference between cow's milk and human milk.

Young infants cannot take cow's milk undiluted, as it contains three times too much casein in proportion to the other ingredients. The error is usually remedied by dilution of the cow's milk with barley water, lime water, solution of gelatine or other diluent; but correction in this manner of one error leads to another, viz., that the milk so diluted is too poor in fat or cream, as well as milk sugar, and the child is very liable to suffer from rickets in consequence. This is emphasized in Clifford Allbutt's System of Medicine, vol. iii., p. 132, where Dr. Cheadle says, "Rickets is a disease the result of faults of diet, and consists in a deficiency of certain elements of food. . . . . The chief and constant defect appears to be an insufficient supply of animal fat, and therewith also in certain cases a deficiency of earthy salts in the shape of phosphates."

In the case of infants who are carefully hand fed, the deficiency of cream in the milk so diluted is remedied by skimming cream from the top of ordinary cow's milk and adding it after dilution. The cream skimming is a tedious business, and it is to avoid this process that the apparatus under our notice has been made.



The apparatus consists of a large glass milk jar, containing about a pint and a half, graduated and covered with a glass top. From the bottom of this jar rises a small glass tube inserted through a rubber cork and capable of being reversed in position and acting as a syphon. There is also a graduated measure for the addition of lactose to the milk after dilution. The method of using is as follows:—The glass jar is filled

with ordinary cow's milk up to the top mark. It is set aside, preferably in a refrigerator or in iced water, and in two or three hours the cream will have risen to the top, occupying from one to two graduations of the scale. The vertical side tube is now reversed and the milk drawn off to the required amount, for young children usually down to the ninth or tenth graduation. Milk sugar is now put into the measure up to the graduation corresponding to the upper level of the milk in the big jar, and is added to the milk. This is then diluted to the original volume with lime water or barley water, and is ready for sterilization or immediate use. The skim milk may, of course, be kept for cooking purposes.

The whole apparatus is very simple, quick, and easily cleaned, and from personal examination we were much impressed with its practical utility, especially for private practice, where hospital conveniences may not be obtainable.

The apparatus is made to hold one and a half pints of milk and will cost to the public 10s. 6d. It may be obtained from Messrs. Toogood & Co., Heddon Street, Regent Street.

SOMATOSE.

It is certainly a misnomer to refer to this preparation under the heading of "Novelties." Somatose has by now gained for itself, in this Hospital at least, a recognised position as a dietary agent in disease. The chief, and in fact vital difference, between this substance and the meat extract class of preparations, lies in the fact that it is a *food* and not merely a stimulant. Easily soluble, that is if the directions are rigidly adhered to, tasteless and peculiarly non-irritating, it is frequently retained when all other forms of food are inadmissible. In this Hospital it has been given in cases of chlorosis, gastric ulcer, malignant growth of stomach, phthisis, etc., and has fully justified its use. There are many other conditions, which suggest themselves, where an easily assimilated, non-bulky food is of great value, and we have received notes of cases in which Somatose has been successfully employed in rickets and in general convalescence. Its use, however, in this Hospital has been sufficient to substantiate its claim to be a "very valuable nutritive agent."

Papers by Guy's Men.

A Case of Puerperal Septicæmia, in which a favourable result was obtained from one injection of Antistreptococcus Serum. By H. W. Webber, M.S. Lond. (with charts).—*British Medical Journal*, February 17th.

Clinical Lecture on Chronic Enlargement of Bursæ. By A. H. Tubby, M.S., F.R.C.S.—*Clinical Journal*, 7th March.

Experiments to determine the efficacy of the different constituents of Haffkine's Plague Prophylactic. By C. Balfour Stewart, M.A., M.B., Camb.

Reviews.

Dictionaire des Termes de Médecine. Français-Anglais. Par H. de Méric, M.R.C.S. Eng., etc. (Baillière, Tindall & Cox, London). 4s. nett.

Such a dictionary as this is absolutely indispensable to the English student of medicine who wishes to read French papers and manuals in the original. Many terms used in the two countries are sufficiently similar to cause no difficulty in their translation; on the other hand, a fair proportion at once show the necessity for this work. Certain words require a phrase in English for their interpretation, *e.g.*, "Happement," the property of certain minerals to adhere to the tongue, while others in no way convey their meaning directly—"Isodique" = Centripetal; "Conturier" = Sartorius muscle, etc. With the exception of a few printer's errors, unavoidable in a work of this nature, this dictionary is extremely complete and accurate and of much practical value.

Surgical Wardwork and Nursing—A Handbook for Nurses and others. By Alexander Miles, M.D., C.M., F.R.C.S. Edin., Surgeon to Leith Hospital. (The Scientific Press, Limited). 3s. 6d.

The author has adopted the useful plan of dividing the contents of this work into sections.

Section I., deals with Antiseptic Surgery, and gives a very good idea of the general principles to be observed therein, although in some details his methods appear to us rather antiquated.

Section II., describes the Nurse's duties in Surgical Operations and Special Nursing.

Section III. The use of Rest in Surgery.

Section IV. Bandaging. This is of special interest to nurses, who, as a rule, are not instructed as they should be in this subject.

On the whole, a sound and useful manual.

A Manual of Chemistry, etc. By A. P. Luff and F. J. M. Page. (Cassell & Co., London. 7s. 6d.)

A new edition of this popular text-book is well-timed. For although it has done good service for some time as the book most suited in its scope for students for the First Conjoint, yet it was being felt on all sides that it possessed many defects and did not fully meet the requirements of the student. Consequently it was in danger of being replaced by some of its, in other respects perhaps, inferior competitors. It must be said that this new edition is a great improvement on the previous text-book; many important additions dealing with fundamental chemical principles, such as the Mendeljeeff classification of the elements, have been made. The part devoted to organic chemistry has received special attention and revision, and not the least important innovation is the more thorough treatment of the structure of organic compounds, by which the student is given a clearer

insight into the general principles of organic chemistry. On the whole, every endeavour appears to have been made to bring the student in touch with the latest chemical facts and theories without overloading him with too much detail.

Anæsthetics: their Uses and Administration. By Dudley Wilmot Buxton, M.D., B.S., M.R.C.P. Third Edition. (London: H. K. Lewis, Gower Street, W.C.) 6s.

The demand for this excellent text-book has necessitated the publication of a third edition. The author has taken the opportunity thus afforded him of revising the whole work, and by judicious employment of material has made it thoroughly up to date, without departing from the convenient size of the former editions. For the benefit of the beginner an introduction has been added, in which special chapters are noted for first reading and a general method of study suggested. Two important additions in this work are a description, with figures, of Dr. Flux's "open method" of administration of nitrous oxide gas, and an extremely interesting section on the infiltration methods of inducing local anæsthesia.

Midwifery Notes. By T. A. Glover, M.D. Edin. (Edinburgh: E. & S. Livingstone.) 2s. 6d. net.

The author distinctly states that the object of these notes is to help the student in his practical midwifery training and not to replace any existing text-book. To this end, only matter which is likely to be exemplified in the ordinary run of cases is included, and this in such a manner as to be easily digested and as easily retained. The book can be read in an hour without any mental strain, and will be found to be a useful little introduction to the art of midwifery. The printing and letterpress leave nothing to be desired.

A Manual of Surgical Treatment. By W. Watson Cheyne and F. F. Burghard. In six parts. Part II.

This volume is divided into two parts. The first deals with the treatment of deformities and the second with the treatment of the affections of the tissues, skin and its appendages, veins, arteries and lymphatics, nerves, muscles, tendons, etc.

That ubiquitous and chronic trouble known as flat-foot is fully dealt with, and will amply repay perusal by the house-surgeon or practitioner alike. Five distinct stages are described and the appropriate treatment of each stage enlarged upon.

In chapter 4, a copy of the directions given to the parents of infants at the Paddington Green Children's Hospital is inserted. What regard the general run of hospital patients pay to the printed papers distributed to them, about matters hygienic, is doubtful—not very much we opine—as the information given during the last decade seems to have permeated a very small part of the Borough population, still, the directions printed here are fuller and more comprehensive than any we have at Guy's, and deal not only with the diet but also the clothing and hygiene of infants. "Keep the window open all night in warm weather." "Keep a small fire burning all night in cold weather." We should prefer that the window be kept open summer and winter and a small fire added in winter.

A good practical statement, in speaking of the treatment, by means of splints, of rickety curvature of the tibia and fibula, is that their usefulness lies entirely in preventing the curve from increasing, and not in actively bending the bone back into its normal position, so that the application of any force in applying these splints is unjustifiable. Another useful detail is given, when dealing with those very thin-walled cysts on the face and elsewhere, which every operator is desirous of removing intact as a proof of his dexterity, that is, make two incisions, including the thinned skin between the incisions, and remove it with the cyst.

We often wonder why so much space is invariably given in modern books and so much time spent by our senior lecturers on the treatment of aneurysms. Cases of aneurysm capable of being dealt with surgically are, if one may argue from recent records, few, comparatively speaking, yet it is quite customary to see this subject repeatedly dealt with in the very fullest manner. This volume is no exception to the rule, and the last two chapters are devoted to this question.

The whole book strikes us as being more interesting and valuable than its precursor, and gives greater promise of even better things in the remaining four volumes.

Catechism Series. Materia Medica (Part I.), *Surgical Anatomy and Operations* (Part II.). (Edinburgh: E. & S. Livingstone). 1s. net.

Two new additions to this well-known series have been published. The little surgical hand-book is apparently compiled from questions actually put in viva-voce examinations, and would be useful as a species of home trainer for these objectionable encounters. The illustrations are good and unambiguous. The value of the Materia Medica volume is less obvious.

Also received:—Clinical Journal (4), Hospital (4), St. George's Hospital Gazette, Quarterly Journal of Balneology and Climatology, Medical Temperance Review (2), Le Mois Médico Chirurgical, Middlesex Hospital Journal, London Hospital Gazette, Treatment (2), St. Thomas' Hospital Gazette, The Broad Way (Cartoons).

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Royal College of Physicians of London
AND
Royal College of Surgeons of England.

DIPLOMA IN PUBLIC HEALTH.

SYLLABUS FOR THE EXAMINATION.

PART I.

The first part of the examination will have reference to the general principles of sanitary science, and will comprise the following subjects:—

The elements of chemistry, physics, and geology. Methods of examination of water and air for hygienic purposes, including a knowledge of analytical methods and the interpretation of results. The chemical composition of foods, and the usual forms of adulteration. The laws of heat and the elements of pneumatics, hydrostatics, and hydraulics, in their relation to warming, ventilation, water-supply, and drainage. Principles of building-construction in their application to dwellings, hospitals, and schools, &c. Meteorology in relation to health; meteorological instruments, their construction and use. The general principles of sanitary engineering, including the disposal of sewage and refuse. The reading and interpretation of geological and ordnance survey maps. The microscopical examination of foods and the detection thereby of the common forms of adulteration. The methods of bacteriological analysis, and the bacteriology of water, air, food, and soil. Disinfectants, their chemical and bacteriological efficacy and use. The general pathology of infection, and the diseases of animals that are transmissible to man. Nature of immunity and protection from infectious disease.

PART II.

The second part of the examination will have reference to the application of the principles of sanitary science, and will comprise the following subjects:—

Laws and statutes relating to public health, including the model bye-laws of the Local Government Board. General Epidemiology with reference to the origin, pathology, symptoms, propagation, geographical distribution, and prevention of epidemic, endemic, and other diseases at home and abroad. Unwholesome trades and the diseases to which they give rise, and the prevention of nuisances arising therefrom. Nature and origin of parasitic diseases. Nuisances injurious or dangerous to health. Causes and conditions which produce climate, general effects of climate, acclimatisation. Effects on health of overcrowding, vitiated air, impure water, polluted soil, and bad or insufficient food. Duties of sanitary authorities and their officers.

Vital statistics:—Calculation of population, birth-rate, marriage-rate, and death-rate; mortality from zymotic diseases; sickness rates; relation between occupation and mortality; life tables, their construction and interpretation; the value of statistical facts, averages, and methods.

FREDERIC G. HALLETT, Secretary.

Sport.

Rugby Football.

GUY'S v. RICHMOND.

(Guy's, 4 points; Richmond, nil).

The conditions of ground and weather were most favourable last Saturday, when this match was played at the Richmond Athletic Ground before a fair attendance. Both sides were below their full strength, and we were kept waiting for some time owing to the non-appearance of one of the home team; it was decided in consequence to play short spells, an arrangement which met with the approval of more than one of the untrained emergency men who turned out to represent the Hospital. Mullins having lost the toss, the game was started by Lawry, who kicked-off against a stiffish breeze. Richmond returned into touch, and for about ten minutes we were kept on the defensive. The scrimmages were of a scrambling order, but Guy's generally got the ball, and by a series of loose rushes cleared their lines. The game now became much faster, the three-quarter lines on either side being kept busy, but their work was usually marred by wild passing and fumbling, in which the Richmond backs were the worse offenders. Their forwards, however, attacked once or twice, but without avail, as they found the tackling of Trail and Harrison very deadly, while the latter made ground by finding touch well when he returned the kicks. Half-time arrived with no material advantage to either side, but Guy's going very strong.

On recommencing, our forwards rushed down into their opponents' twenty-five, Manson being chiefly conspicuous in the loose. After a bout of short passes, Hicks, on the left wing, took the ball well, and essayed a left foot screw kick at goal, which only missed the post by a few feet. Richmond touched down, and O'Brien taking the drop-out, turned the favouring wind to good account by dropping a good goal from nearly the half-way line. Richmond tried hard to equalise, but their backs did not show to much advantage, and though they once worked us down on to our line, they were scarcely ever dangerous. Our forwards, on the other hand, heeled remarkably well at times, and gave the backs numerous chances which should have added to our score but for frequent mistakes in passing. Hicks just missed scoring once, being forced into touch at the corner flag, while Manson, getting well away from the line-out, also looked dangerous. Play continued fast, with Guy's having just a trifle the better of it until the call of time, which left us victors by 1 dropped goal (4 points) to nil. Team:—

Guy's.—E. M. Harrison (back); E. Morgan, C. D. Pye-Smith, A. O'Brien, J. T. Hicks (three-quarter backs); M. Louisson, S. C. Brown (half-backs); R. C. Mullins, D. H. Trail, P. Manson, A. H. Wall, R. C. Lawry, E. H Milsom, G. Shorland and F. G. Gibson (forwards).

GUY'S 2nd v. STREATHAM.

(Guy's, 17 points; Streatham, nil.)

This match was played at Honor Oak Park, on Saturday, March 3rd. Guy's were never pressed, and won easily against a weak side. As seems to be frequently the case in such games, the forwards did not exert themselves, and the packing and heeling was of the most slovenly description. Brown scored two tries from passes by Pye-Smith. The former is a strong runner and with more knowledge of the game should be very useful. Kynaston should endeavour to pass more accurately to his three-quarters. Team:—

Guy's.—R. D. Bridger (back); H. S. Brown, C. D. Pye-Smith, W. Jarvis, J. T. Hicks (three-quarter backs); A. E. Kynaston, S. C. Brown (half-backs); A. R. Thompson, D. P. Watson, H. B. Milsom, R. Beaumont, G. Nunn, G. Watts, M. A. Collins (forwards).

GUY'S 2nd v. MARLBORO' NOMADS "A."

(Guy's, 18 points; Marlboro' Nomads, nil).

Played in fine weather at Surbiton, and won by Guy's by 3 goals and 1 try to nil. We gave our opponents two men as they were five short. The game was of a fast and loose kind. The tackling was, on the whole, very poor, and will not do for next Saturday. Kynaston should avoid giving the ball to the opposing backs by short miskicks. Bridger played well at back. Team:—

Guy's.—R. O. Bridger (back); H. S. Brown, H. A. Grose, W. Jarvis, H. T. Palmer (three-quarter backs); A. E. Kynaston, J. Pallant (half-backs); D. P. Watson, R. G. Anderson, G. T. Collins, R. P. Marshall, H. Rendall, G. Watts, N. B. Odgers, M. A. Collins (forwards).

Association Football.

CENTRAL TECHNICAL COLLEGE v. GUY'S 2nd.

(Guy's, 4 goals; Central Technical College, nil).

The above match was played at Acton, and resulted in a win for the Hospital by 4 goals to nil, thus wiping out the only defeat we have suffered this season.

The team was several men short—a deplorable state of affairs considering that the next match is the Final. The vacant places were filled by men from the 1st, Barber playing left back, Norton inside left, Chignell inside right, and a sub. right half.

The Hospital had all the game during the first half, Lacey, the sub. and Dent scoring. Only on one occasion did our opponents look like scoring, and Heap, by a brilliant save, spoiled their opportunity.

In the second half the game partook of the "kick and rush" description, being only remarkable for hard kicking and poor combination. Several good runs were made by the wings, Peall and Dent both doing good work, but most of them were futile, except one, which Norton utilised, and, by a fine piece of individual play, succeeded in making the last point.

GUY'S 2nd v. ST. MARY'S 2nd.—Final of Inter-Hospital Junior Cup.

(St. Mary's, 3 goals; Guy's, 2 goals).

Played at Chiswick on Tuesday, March 13th. Guy's lost the toss, and Lacey kicked-off with the wind and sun in his face. For the first five minutes play was mostly in Mary's half; Horsley and Lacey making a rush, led to a corner, which was not turned to advantage. Soon after this, Dent should have scored from a centre by Peall, but hit the post instead. Play after this was very even, but again Guy's got away, and Peall just missed scoring by about a foot. Mary's then began to grow dangerous in front of Guy's goal, but nothing was scored. On the ball coming back to the Mary's half, two corners were awarded, but neither was improved upon. Rust, at half, was playing a strong game about this time, and got through a lot of work. Just when Guy's seemed to be having the better of the exchanges, Mary's scored the first point from a slight scrum in front of goal. On kicking-off again, play was all over the field. Dent on the right, however, got the ball, and running up the wing, put in a good centre from which Lacey scored a goal, equalising the score. It was not long before Roberts again got away, and passing across to Peall, who put in a stinging shot, and gave Guy's the lead. At half-time the score was still Guy's 2, Mary's 1.

In the second half our forwards fell to pieces, and though they now had advantage of wind and sun, failed to hold the ball whenever they happened to get it. Poor condition of some of the men also began to tell, Smith at right half being apparently in great distress. Mary's showed better combination, and though our backs were the most reliable men in the team, they were frequently unable to keep out their vigorous attacks. Heap made a splendid save during one of these onsets, but the referee decided that he carried the ball beyond the legal limit, and gave a free kick in goal from which Mary's scored. This decision was open to grave criticism, as Heap certainly appeared to clear the ball before he took the second step. After this, Mary's had the better of the game, and scored their third goal from a centre which Rust should have cleared. Guy's now seemed to realise that the Cup was slipping through their fingers, and made strenuous efforts to score, but were unable to do so, though Horsley once had bad luck. When the whistle blew, the score was Mary's 3, Guy's 2.

On the whole, the game was somewhat slow, though at times it became very fast. Heap, in goal, gave nothing away, and made some good saves. The backs played well, Leeming being especially safe; Bent played a strong game, but his kicking was somewhat wild. Of the halves, Rust played a fair game. Brydone however was very much missed here. The forwards lacked their usual dash and combination, especially in the second half. Lacey tried hard to save the game, but his efforts did not gain the end which they deserved. In this manner passed away the last of the three sister cups. R. I. P. Team:—

Guy's.—E. T. Heap (goal); —. Leeming, V. E. Bent (backs); F. M. Smith, S. Bent, C. Rust (half-backs); R. Dent, W. O. Roberts, H. K. Lacey, C. Horsley, P. A. Peall (forwards).

Appointments.

CIVIL.

Berry, H. Pool, M.B. Lond., M.R.C.S., has been appointed Medical Officer of Health for the Grantham Urban Sanitary District.

Eccles, Horace D., L.R.C.P. Lond., M.R.C.S., has been appointed Public Vaccinator for the District of Wanganui, New Zealand.

Fagge, C. H., M.S., F.R.C.S., has been appointed Surgeon to the Out-patients of the Evelina Hospital for Sick Children, Southwark Bridge Road, London.

Hopkins, A. D., L.D.S. Eng., has been appointed Dental Surgeon to the Jews' Hospital and Orphanage Asylum, West Norwood, S.E.

Jacobson, W. H. A., M.Ch., has been appointed Examiner in Surgery at the Royal College of Surgeons.

Kendall, Bernard Charles, L.R.C.P. Lond., M.R.C.S., has been appointed Honorary Medical Officer to the Helston (Cornwall) Public Dispensary.

Kirkman, A. H. B., L.R.C.P. Lond., M.R.C.S., has been appointed by the Secretary of State for War to the charge of the X-ray Department of the Field Hospital, Eighth Division of the South African Field Force.

Muriel, G. Bertram, M.B., B.C. Cantab., M.R.C.S., L.R.C.P. Lond., has been appointed Honorary Visiting Surgeon of the Whitehaven and West Cumberland Infirmary.

Pigeon, H. W., M.A., M.C. Camb., F.R.C.S., has been appointed Surgeon to the Hull Royal Infirmary.

Richardson, Walter Silverwood, M.D. Brux., L.R.C.P. Lond., M.R.C.S., has been appointed Assistant Physician to the Boscombe Hospital, Bournemouth.

Shorland, Ernest Trevor, L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer to the Wiltshire, Gloucestershire, and South Wales Regiment of the Imperial Yeomanry.

Spriggs, Edmund Ivens, M.D. Lond., M.R.C.P. Lond., has been appointed Physician to the Surrey Dispensary, *vice* T. B. Partridge, resigned.

Sykes, Dr. John F. J., has been appointed by the Royal College of Physicians Milray Lecturer for 1901.

Ta'Bois, Fred. W., L.D.S. Eng., has been appointed Honorary Dentist to the Woodford Jubilee Hospital, Woodford Green, Essex.

Webber, H. W., M.S., M.D., L.R.C.P. Lond., M.R.C.S., has been appointed Assistant Surgeon to the South Devon and East Cornwall Hospital.

NAVAL AND MILITARY.

R. Tilbury Brown, M.B., Dunelm., has obtained the nomination for the Royal Army Medical Corps given to Guy's Hospital.

Surgeon Edward Pain Mourilyan is promoted to be Staff-Surgeon in Her Majesty's Fleet. Surgeon J. F. M. McDougall has been appointed to H.M.S. *Rodney*.

Sheen, William, M.D., M.S. Lond., F.R.C.S., L.R.C.P., has been appointed Surgeon on the Staff of the Imperial Yeomanry Field Hospital.

Francis Wellford, M.B., has been appointed a Medical Officer, with the temporary rank of Captain, to the Imperial Yeomanry.

Dr. E. S. Robson has been appointed a Justice of the Peace for the City of Durham.

PRESENTATION.

On February 14th, at the Municipal Offices, Liverpool, Mr. E. P. Manby, M.D. Cantab., the Assistant Medical Officer of Health, who is about to leave for London, having been appointed on the Medical Staff of the Local Government Board, was presented with an inkstand, suitably inscribed. Dr. Hope, in making the presentation on behalf of the Staff, wished Dr. Manby every happiness and success in his new position.—*Lancet*, 24th February.

Birth.

CURRIE—On March 10th, at Maritzburg, Natal, South Africa, the wife of Oswald James Currie, M.B., M.R.C.S., of a daughter.

Marriage.

PAKES—FISHER.—On March 1st, at St. Andrew's, Fulham, by the Rev. Charles Pakes, B.A., Vicar of Copp, Garstang, father of the bridegroom, assisted by the Rev. J. S. Skinner, B.A., brother-in-law of the bride, Walter Charles Crass Pakes, L.R.C.P., D.P.H., to Dora Agnes, youngest daughter of the late John Fisher, Esq., of Leckonby, Great Eccleston, Lancs.

Deaths.

DUKE.—On February 22nd, at Villa Albert, Cannes, Douglas William Duke, aged 51.

WILLIAMS.—At Brynymor, Penygroes, Carnarvonshire, on the 12th instant, John Cadwaladr Williams, M.B., C.M. Edin., M.R.C.S. Eng., L.R.C.P. Lond., of Grange Road West, Middlesboro'-on-Tees, aged 31.

Ed.—S. H.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well a subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

March, 1900.

Sat. 31.—Messrs. Jacobson and Fripp's take-in; Drs., E. T. Claxton and G. S. Davidson; Cl., W. G. Stewart.
Last day for applying to Registrar for Form of Entry for Final M.B. Lond.

April.

Mon. 2.—First M.B. Durham Exam. begins.
May Appointment List opens.
Cambridge Third M.B. Schedules to be brought to Medical School Office for signature.

Tues. 3.—First part of the Cambridge D.P.H. Exam. begins.
Final Conjoint Exam. begins.

Thur. 5.—Messrs. Howse and Symonds' take-in; Drs., H. A. Ehrlich and F. D. Welch; Cl., B. W. Moss.

Sat. 7.—May Appointment List closed.

Mon. 9.—Second M.B. Durham Exam. begins.

Tues. 10.—Second part of the Cambridge D.P.H. Exam. begins.

Wed. 11.—Schedules for L.D.S. Eng., with the Certificate of Mechanical Dentistry already signed, to be left at the Medical School Office not later than this date.
Test Exam. for L.D.S. Eng.

Thur. 12.—Messrs. Lucas and Lane's take-in; Drs., N. F. Ticehurst and F. W. Sime; Cl., G. Lewin.

Fri. 13.—Good Friday.

Guy's Hospital Gazette,

MARCH 31, 1900.

Ascites.

CLINICAL LECTURE BY DR. BRYANT.

February 3rd, 1900.

GENTLEMEN,—During your hospital career you will have the opportunity of seeing a good number of cases of ascites. Between the years 1888 and 1898 inclusive, 501 cases were admitted into the medical wards of this hospital, *i.e.*, an average of about 45 cases each year. In women it may be often difficult to distinguish ascites from ovarian tumour and other conditions which cause general abdominal distension. Both in males and females, when you have come to the conclusion that the abdominal distension is due to the presence of fluid in the peritoneal cavity, you will often find it very difficult to determine the actual cause of the condition. You must not be satisfied with a diagnosis of ascites; you must go further and endeavour, if possible, to find out what morbid condition is producing it. You must look upon ascites as the indication of, or the chief symptom of a disease, and not as a disease itself. It may be produced by a great variety of conditions—Bright's disease, cirrhosis of the liver, tuberculous peritonitis, or cardiac disease. If you do not determine the cause, how can you expect to give a prognosis, or to treat your patient with any hope of success? Some of the cases will present very few difficulties, whereas, in others it will be almost impossible to determine the primary condition producing the ascites.

I have at present under my care in John ward, a patient suffering from ascites, the primary cause of which we have not at present been able to determine.

In this lecture I shall, first of all, give you an account of the physical signs of ascites. I shall then tell you how to distinguish it from other conditions which may simulate it, then give you a classified list of the causes, and finally tell you the chief points about each particular variety, which will help you, I hope, to make a correct differential diagnosis when you come across a case in practice.

PHYSICAL SIGNS.

Inspection.—The abdomen is uniformly distended. The degree of the distension, however,

varies with the amount of fluid present. If the quantity of fluid is large, and its accumulation has been rapid, the abdomen presents a rounded, globular appearance, the umbilical region being most prominent. The skin is tense and shiny in appearance. If the quantity of fluid is large, but its accumulation has been gradual, bulging of the flanks is the most prominent feature of the general distension. With large effusions the skin may show well-marked lineæ albicantes in the lower half of the abdominal wall, and the lower ribs may be somewhat pushed outwards. If the quantity of fluid is small, only a slight bulging of the flanks may be noticed. It must, however, be remembered that the appearance of the abdomen depends a good deal on the position of the patient. The above description applies to a patient lying flat on the back. If lying on one side more than the other, the most dependent part is the most prominent, as the fluid gravitates to that side of the abdomen. If the patient stands or sits upright, the hypogastric and iliac regions will be most bulged.

The umbilicus may be flattened or protruded, and umbilical hernia may result from separation of the recti; it retains its position, however, in the median abdominal line, but may be nearer to the pubes than the ensiform cartilage. In tuberculous peritonitis, the skin in its immediate neighbourhood may be reddened, inflamed and œdematous. In cirrhosis of the liver, the veins around the umbilicus may be dilated, forming the so-called caput medusæ. The superficial veins all over the abdomen and lower part of the chest may be dilated, the blood flowing in an upward direction; this condition occurs in portal obstruction, and also when the inferior vena cava is obstructed.

The abdominal respiratory movements may be absent or much diminished. The cardiac impulse may be displaced upwards and outwards.

The legs and thighs may be œdematous.

Palpation.—The abdomen may be very tense or quite flaccid.

A fluid thrill may be obtained by placing the palm of one hand flat against one of the lumbar regions, and by flicking the other flank with the fingers of the other hand; a distinct wave or slight shock may then be felt by the hand which has been placed flat on the lumbar region. The possibility of a thrill which is transmitted in the abdominal wall, especially if it is thick, must be eliminated by getting the patient or an assistant to place the side of his hand, or the edge of a bed-letter on the front of the abdomen. This procedure has the effect of stopping this thrill at the point of contact of the hand or bed-letter with the abdominal wall. If the above precaution is taken, and a thrill is still obtainable, it denotes the presence of fluid.

If the liver and spleen have enlarged, they sink in the fluid, so that between these organs and the abdominal wall, a layer of fluid is present. If the tips of the fingers are placed on the abdomen in the right or left hypochondriac regions, as the case may be, and then are suddenly depressed, the fluid is displaced, and the surface of the enlarged organ can then be felt. This particular form of examination is called the method of displacement or dipping. The direction of the blood-flow in dilated veins, the position of the cardiac impulse, and the diminished respiratory movements may be confirmed by palpation.

Percussion.—When the patient lies flat on his back, the fluid gravitates to the posterior part of the abdomen, and the air-containing viscera float to the anterior part, so that the percussion note is resonant in front and dull in the flanks. As the fluid increases in quantity, the line of dulness creeps forward, and in extreme cases the abdomen may be dull all over. This is not at all uncommon in children suffering from ascites.

The most important physical sign of ascites is the effect produced on the percussion note by a change in the posture of the patient. If after examining a patient lying on the back, and finding dulness in the flanks and resonance in the front, he or she be turned on one side, the uppermost flank now becomes resonant, and the line of dulness on the other side rises nearer to the median abdominal line. This phenomenon is due to the fluid gravitating to the most dependent part.

In some conditions which produce ascites, shortening of the mesentery is associated; the intestines cannot then rise, and the result is dulness all over the abdomen, *e.g.*, in some cases of tuberculous peritonitis. In chronic peritonitis there may be local collections of fluid on account of matting together of the intestine. The abdominal distension may not be uniform in such a case, and change of posture may not alter the character of the percussion note.

If a very small quantity of fluid is present, the abdomen may be resonant all over when the patient lies on the back; if such be the case, place the patient in the knee-elbow position, and then on percussion the umbilical region may be found to be dull.

Mensuration. — The abdomen should be measured, fixed points being taken in front and behind, *e.g.*, the umbilicus in front, and the tip of the third lumbar spine behind. This is important in order to watch the effect of treatment. The distance of the umbilicus from the ensiform, pubes, and anterior superior iliac spines should also be noted.

It is nearer to the pubes than the ensiform, and is equi-distant from the anterior superior iliac spines.

A very important point to remember is to always examine carefully the abdomen after paracentesis has been performed. The diagnosis of the cause of the ascites can often be made or confirmed in this way, tumours and enlargements of organs being made out which previously were hidden or obscured by the tenseness of the abdominal wall. When speaking to you of perihepatitis I shall read some notes of a case which illustrates this point.

Diagnosis of ascites.—Ascites has to be distinguished from other conditions which may give rise to general abdominal distension.

1. Tympanites.
2. Ovarian and parovarian cysts.
3. Gravid uterus with hydrops amnii.
4. Distended bladder.
5. Distension associated with obesity.
6. Phantom tumour.
7. Large abdominal cysts.

Tympanites is distinguished from ascites by the following signs:—

a. The outline of distended coils of intestine may be visible, and peristaltic movements may be noticed.

b. There is no fluid thrill if the above-mentioned precautions to prevent a thrill being transmitted by the abdominal wall are taken.

c. The abdomen is resonant all over, both in front and in the flanks.

Ovarian cyst.

a. There may be a history of the enlargement of the abdomen having at an early date been noticed to be more on one side than the other, and to have arisen from the pelvis.

b. The umbilicus may be nearer to the ensiform cartilage than the pubes, and nearer to one anterior superior iliac spine than the other.

c. A fluid thrill may not be obtained far back in the flanks, but only be noticed in front of the mid-axillary lines.

d. There is usually dulness in front with resonance in the flanks.

e. The outline of the cyst may possibly be noticed during the respiratory movements.

f. On measuring the abdomen the greatest circumference is usually below the umbilicus, whereas, in ascites it is generally at the umbilicus.

g. A vaginal examination may reveal that the uterus is drawn upwards and that its mobility is impaired, whereas, in ascites it is low down and movable.

h. If paracentesis has been performed the nature of the ovarian fluid is characteristic, it usually being thick, tenacious, viscid, and of a brownish or greenish colour; whereas, ascitic fluid is yellowish, limpid, and clear.

I have seen now a number of cases of ascites mistaken for ovarian cyst, and of ovarian cyst mistaken for ascites. I remember in particular a patient who was examined in the front surgery by the House-physician and the Obstetric-Resident. After they had discussed the physical signs and symptoms she was admitted into the Obstetric ward as a case of ovarian tumour. There she was seen by the Obstetric Physician, and, later, by one of the physicians in consultation, both of whom diagnosed ascites, and she forthwith was transferred to a medical ward where paracentesis was performed on account of the enormous distension interfering with the respiratory movements and the cardiac action. The fluid withdrawn proved to be thick, viscid, of a dark-brownish colour, and was obviously not ascitic, but ovarian. A laparotomy was subsequently performed, and the distension was definitely proved to be due to an enormous ovarian cyst.

Gravid uterus with hydrops amnii.

In this condition it may be possible to make out:—

a. The outline of the enlarged uterus; and the tumour may vary in consistency.

b. On vaginal examination, the cervix is soft and patulous, and the uterus is enlarged.

c. The presence of other signs of pregnancy, the characteristic condition of the breasts, fœtal movements, etc., and the history of amenorrhœa.

A *distended bladder* may reach well above the level of the umbilicus. This condition occurs most frequently in women as the result of a retroverted gravid uterus. The most important symptoms are: incontinence of urine from over-distension, and abdominal distension. If there is any question of such a condition being present, the passage of a catheter will clear up all doubt.

The abdomen may be much distended as a part of *general obesity*. The mesentery, omentum, and abdominal wall may be very much thickened with fat. I remember once

performing a post-mortem and finding the abdominal wall four and three-quarter inches in thickness. Under such conditions it is very difficult to make a satisfactory examination, and it is almost an impossibility to definitely determine the presence of a small or even a moderate amount of fluid.

The abdomen may occasionally be much distended in women, especially at the time of the climacteric. Such a distension may present difficulties in diagnosis, and may be mistaken for ascites, ovarian tumour, or pregnancy. If an anæsthetic is administered the distension often disappears, the rigid abdominal wall becomes flaccid, and it can be determined with certainty whether fluid in the peritoneal cavity or any abdominal tumour is present or not.

Occasionally large abdominal cysts may simulate ascites, *e.g.*, hydronephrosis, pancreatic cyst and hydatid cyst; they do not, however, as a rule, cause uniform distension of the abdomen. They are most likely to be mistaken for simple chronic peritonitis, in which case local collections of fluid may occur, owing to matting together of the intestines.

Hydronephrosis may be distinguished by its position and by the fact that it may vary in size, a decrease being associated with an increase in the amount of urine passed.

Pancreatic cyst may be differentiated by its position in the upper part of the abdomen.

If paracentesis abdominis has been performed, the character of the fluid would point to the nature of the disease in each of the three above-mentioned conditions.

Having made up your mind that the general abdominal distension is due to the presence of fluid in the peritoneal cavity, you must next differentiate the cause of the ascites. In order to do this you must first of all have a knowledge of the possible conditions which give rise to ascites. I have found the following classification most practical and useful:—

Ascites.

1. *Diseases of the peritoneum.*
   - *a.* Simple acute peritonitis (non-suppurative).
   - *b.* Simple chronic peritonitis.
   - *c.* Tuberculous peritonitis.
   - *d.* Malignant peritonitis.
2. *Portal obstruction.*
   - A. Diseases of the liver.
     - *a.* Cirrhosis.
     - *b.* Perihepatitis.
     - *c.* Carcinoma.
     - *d.* Syphilis.
   - B. Pressure on the portal vein.
     - *a.* Tumours of the liver { Carcinoma. / Sarcoma. / Abscess. / Hydatid.
     - *b.* Tumours of the pancreas { Carcinoma / Hydatid
     - *c.* Tumours of the kidney.
     - *d.* ,, stomach.
     - *e.* ,, duodenum.
     - *f.* ,, colon.
     - *g.* ,, suprarenal.
     - *h.* Enlarged glands { Malignant. / Lymphadenomatous. / Tuberculous.
     - *i.* Aneurysm of the hepatic artery.
     - *j.* Thrombosis of the portal vein.
     - *k.* Obstruction of the inferior vena cava above the hepatic veins { Thrombosis. / Pressure from mediastinal growth.
   - C. Backward pressure in:— { Chronic heart disease. / Chronic bronchitis and emphysema. / Fibroid lung,
3. *Bright's disease.*

   In Bright's disease ascites may be caused in four different ways:—
   - *a.* It may occur as part of a general dropsy.
   - *b.* Acute peritonitis.
   - *c.* Chronic peritonitis.
   - *d.* Secondary to hypertrophy and dilatation of the heart.
4. *Rupture of an ovarian cyst.*

Differential Diagnosis of the Cause of Ascites.

If ascites is the only fluid accumulation present in the patient, or even if there is swelling and œdema of the legs, but the ascites appeared first, or if the ascites is out of proportion to dropsy elsewhere, it is most probably due to some form of peritonitis, or to portal obstruction from pressure on the portal vein, or disease of the liver. If it is associated with general anasarca, *e.g.*, with œdema of the legs, body and face, with other serous effusions, the probable cause is Bright's disease.

If swelling and œdema of the legs and lower part of the body were first noticed, and the ascites followed: cardiac disease, chronic lung disease, or obstruction of the inferior vena cava above or involving the hepatic veins would be the most likely cause.

If jaundice is associated with the ascites it points to some form of portal obstruction either

in the liver or in the portal fissure as the cause; if the jaundice is intense, to some actual pressure on the portal vein and common bile-ducts, or to carcinoma of the liver.

If enlargement of the liver is associated with it: to carcinoma, cirrhosis, perihepatitis, syphilis of the liver or congestion, the result of backward pressure from chronic heart or lung disease.

If associated with multiple abdominal tumours, to tuberculous or malignant peritonitis.

Simple acute peritonitis.—By this I mean an acute inflammation of the peritoneum which is not due to the perforation of a viscus, or to an abscess opening into the peritoneal cavity. It is a condition analogous to acute pleurisy with serous effusion.

The fluid may be clear; it is usually turbid and contains flakes of pale lymph. It occurs most frequently as a complication of acute or chronic nephritis. The onset is acute, the abdominal distension occurs rapidly, there is considerable pain and tenderness, and the temperature rises to 101–104°. It is usually fatal.

The acute onset and its association with nephritis are the most important points to consider in making the diagnosis.

Simple chronic peritonitis.—By this I mean a chronic inflammation which is not tuberculous or malignant. It may follow simple acute peritonitis, it is usually associated with perihepatitis; it occurs as a complication of nephritis, both acute and chronic, and may follow as a result of repeated paracenteses abdominis.

The peritoneum becomes thickened, and the intestines may be bound down and matted together. The ascites which results may give rise to a general or local abdominal distension, and this depends whether local cavities are formed or not by the adhesions. There may be a little abdominal pain, also vomiting, constipation and albuminuria. On account of the shortening of the mesentery and the matting together of the intestines, there may be dulness all over the abdomen. This form of ascites in particular is liable to be mistaken for ovarian tumour.

Tuberculous peritonitis.—This is the most common cause of ascites in children. There are several varieties, which may be classified according to the morbid changes found in the abdomen.

a. The peritoneum may be studded with tubercles only; the physical signs of this form are simply those of ascites—no abdominal tumour is felt. I have several times seen this condition mistaken for atrophic cirrhosis of the liver. Quite recently I performed a necropsy on a case of malignant peritonitis which during life was diagnosed as tuberculous peritonitis of this kind. It was considered to be a most suitable case for laparotomy, and this operation had been performed a few days before death.

b. The omentum may be contracted and thickened from caseation, and a hard tumour may be felt simulating an enlarged liver; it may, however, be distinguished by the presence of a resonant percussion note between its upper limit and the costal margin, and the edge of the liver may be felt above it.

c. The intestines may be matted together and the adhesions be thickened and infiltrated with tuberculous deposits. In consequence, the peritoneal cavity may be divided up into several smaller loculi, which may contain fluid, so that the distension of the abdomen in such a case will not be uniform.

d. The mesentery may be thickened and contracted, and the intestines bound down to the posterior parts of the abdominal cavity. There may be general abdominal distension, a hard, large, irregular-shaped and deeply situated tumour may be felt, and dulness on percussion may be elicited all over the front of the abdomen.

e. The mesenteric glands may be enlarged and caseous, and on palpation irregular-shaped tumours be felt. Ascites is by no means a constant sign of this form of the disease.

f. Occasionally local thickenings in the abdominal wall may be felt, which are due to subperitoneal inflammatory deposits. This condition resembles the hard, rigid feeling produced by contraction of the recti.

Abdominal pain and tenderness are often marked symptoms of tuberculous peritonitis. In acute cases the temperature may rise to 103° or 104°, and the condition be mistaken for typhoid fever; on the other hand, in more chronic cases the temperature may be subnormal. Occasionally there is redness and œdema for some little distance around the umbilicus, even a purulent discharge from it. Wasting and diarrhœa are usually present.

Cancerous peritonitis usually occurs in patients over forty years of age. The growth is in nearly all the cases secondary. The omentum may be thickened and infiltrated, and large nodules may develope all over the peritoneum. There may be rapid emaciation and marked cachexia. A large quantity of fluid may be present, and if paracentesis is performed it will be found in many instances to contain blood. Evidence of a primary growth may be forthcoming. On palpation, multiple abdominal

tumours may be detected. Ascites may be the first and only evidence of disease. It is with difficulty distinguished unless tumours are palpable. I have already mentioned a case which was mistaken for tuberculous peritonitis.

Cirrhosis of the Liver.—With ascites from this cause there may be a history of chronic alcoholism, the presence of acne rosacea and dilated stellate venules on the cheeks, furred and tremulous tongue, a slight icteric tinge of the skin and conjunctiva, a history of morning sickness and cramps in the legs at night, loss of appetite, epistaxis, hæmatemesis, and melæna, the presence of distended superficial abdominal veins, enlargement of the liver, the surface of which is hard and rough-feeling, and the edge of which is irregular and beaded, enlargement of the spleen, which is a further result of the portal obstruction, and sometimes a bruit over the spleen.

I will tell you about a case in which this last-mentioned curious condition was present. The notes of the case are as follows:—Patient is a female, forty-nine years of age, with a well-marked alcoholic history. She has been accustomed to take alcohol freely with her daughter who is a music hall artiste. She first noticed swelling of the abdomen a year ago. Paracentesis abdominis had been performed six times. She rambled a good deal and her statements were unreliable. She was very tremulous, dilated venules were visible all over her face. Pulse 80 and regular.

The abdomen was distended and there was considerable bulging of the flanks. The umbilicus was protruded and prominent. A curious pulsation which was of a fluttering character was noticed below the left costal margin. The abdominal walls were flaccid. The superficial veins were dilated and the blood was running upwards. The edge of the liver was hard and irregular, and could be felt one-half to three-quarters of an inch below the costal margin. The spleen was considerably enlarged and reached to within a level of the umbilicus. There was no fluid thrill. The flanks were dull on percussion when she was on her back. If she turned over on one side the uppermost flank became resonant. A well-marked systolic bruit could be heard over the spleen.

Perihepatitis.—Unless the liver can be palpated the diagnosis of this disease is most uncertain. The capsule of the liver becomes much thickened and contracts, distorting the shape of the organ, especially of the edge which becomes rounded or turned up. If this curled or turned up condition of the edge can be detected, a certain diagnosis of perihepatitis can be made. Albuminuria occurs in the majority of cases of perihepatitis. The following case is most instructive, and brings out forcibly the necessity of a careful physical examination. The patient was a laundress, thirty-two years of age, and was admitted on October 6th, 1893, under Dr. Goodhart (who has kindly given me permission to mention it) for swelling in the abdomen. She is a widow and has four children. Her father and mother are alive. One sister died of (?) phthisis. She has never had a day's illness in her life before the present complaint came on. There is no history, or evidence, of alcoholism.

About five months ago she caught a chill and became very ill. She suffered from pain across the abdomen, became feverish, and after eating anything she felt herself to be bursting. A month or two after this she noticed that her abdomen was increasing in size. She was at first treated by her medical man, but she did not get any better. She then went to Blandford Cottage Hospital, remained there ten days, and from thence was sent here. She was first admitted into Dorcas ward under Dr. Galabin who diagnosed ascites and had her transferred to Mary ward under the care of Dr. Goodhart.

Condition on admission.—Temperature 98°. Patient is tall and fairly well-nourished. Not jaundiced. Legs, tongue, gums, and fauces healthy in appearance.

Abdomen.—Uniformly distended, umbilicus flat, superficial veins not enlarged. The liver can be felt about three inches below the ensiform cartilage; its edge is thin and sharp, and the surface of the left lobe feels quite smooth. In the nipple-line the liver can also be felt one inch below the costal margin, the edge is sharp and well-defined, and the surface is smooth.

A fluid thrill can be obtained. On percussion, the flanks and hypogastric regions are dull; around the umbilicus a resonant note is obtained. On turning the patient on her side, the uppermost flank becomes resonant, and the area of dulness on the other side reaches to the umbilicus. The girth of the abdomen on a level with the umbilicus is thirty-five and a half inches; the distance from the ensiform to the umbilicus is seven inches, and from the umbilicus to the pubes nine inches.

Circulatory system.—Pulse 100, regular and compressible. Heart sounds normal.

Respiratory system.—Normal.

Urine 1020, acid. Trace of albumen present.

Treatment.—Mist. Potas. Acet. Co.

Diagnosis.—Ascites.

The abdomen became more distended; in fact there was more fluid forming, and on December 7th paracentesis abdominis was performed, eleven and a half pints of clear, yellow, serous fluid being withdrawn. After the paracentesis the edge of the liver could be palpated in the anterior axillary line; *it felt as if it was curled up, and on the strength of this a diagnosis of perihepatitis was made.* On December 14th the patient went out feeling much better, very little fluid having re-accumulated.

Carcinoma of the liver.—Ascites due to this cause is usually associated with intense jaundice. The liver may be felt to be much enlarged, the edge reaching well below the level of the umbilicus. Carcinoma is the cause of the greatest enlargement of the liver. I once performed a necropsy on a case of carcinoma and found the liver enlarged from this cause, and weighing twenty-two pounds; the usual weight of this organ is under four pounds. It may be painful and tender, and large umbilicated nodules may be felt on its surface. There may be indications of the primary growth in some other organ. The patient is usually over forty-five years of age, is wasted and cachectic in appearance.

Last year I had a male patient under my care in Stephen ward, aged sixty-five, who was admitted for ascites and intense jaundice. The age of the patient, the marked ascites with intense jaundice suggested a diagnosis of carcinoma of the liver. A few days after admission he became drowsy, a condition which was soon followed by coma and death. At the necropsy, which I performed, I was astonished to find no sign of carcinoma. The liver appeared to be smaller than normal, and its capsule was very much thickened. The disease from which he suffered was perihepatitis. This did not explain such intense jaundice; jaundice is very rarely produced as a result of perihepatitis. A microscopical examination of the liver cleared up the mystery, for changes characteristic of yellow atrophy were found. I relate this case under this heading, as during life the patient was thought to have been suffering from carcinoma of the liver. The ascites was due to the perihepatitis, and the jaundice to the acute yellow atrophy. The moral is to examine the urine for leucin and tyrosin in every case of jaundice; unfortunately no such examination was made in this case.

Pressure on the portal vein by tumours of adjacent organs and enlarged glands.—Ascites due to any of these conditions is also as a rule associated with intense jaundice, the common bile-duct being involved as well as the portal vein, on account of its close relation to it. Tumours may be felt, and great difficulty may be experienced in determining the nature and origin of them.

Carcinoma of the head of the pancreas may be accompanied by glycosuria and the passage of fatty stools. On account of the relation to the aorta, markedly transmitted pulsation may be felt in the tumour, and further by inflating the stomach it may be demonstrated that the tumour has a posterior relation to that organ.

Renal tumours may be associated with hæmaturia, pyuria, etc. When large they may be difficult to distinguish from an enlargement of the liver.

Carcinoma of the stomach may give rise to obstruction of the pylorus and dilatation of the stomach; there may be vomiting and hæmatemesis.

Thrombosis of the portal vein.—The diagnosis of this condition is difficult. It has to be distinguished from the other forms of portal obstruction, and especially from cirrhosis of the liver. The absence of an alcoholic history and of signs and symptoms of alcoholism are the chief points to consider. The obscure case I mentioned to you, at present in John ward, may possibly be of this nature.

Obstruction of the inferior vena cava above the hepatic veins.—This is a very rare cause of ascites, and, as in cardiac disease, the onset of ascites is usually preceded by swelling and œdema of the legs. I can best illustrate this by telling you about a case. A man fifty-eight years of age, sought advice for loss of flesh, weakness, ascites, and swelling of the legs. He had always had good health until a year before, when he noticed blood in his urine for the first time. A year before this he noticed a sediment like sand in his urine. Three weeks after he passed the blood, he had shooting pains in his right lumbar region, and pain also in his left lumbar region. At this time he noticed more blood in his urine, also some blood-clots. He also had rigors. The swelling of the legs was noticed a few weeks before he was admitted, and this was soon followed by swelling of his abdomen. The urine contained a little albumen, there was no blood present.

Condition on admission.—His legs were swollen and œdematous, and the skin was shiny. The abdomen was tense and uniformly distended. The liver could be felt to be slightly enlarged. There was a well-marked fluid thrill. On percussion a dull note was elicited in the loins,

and a resonant note in front. On making him lie on one side, the uppermost flank became resonant. The superficial abdominal veins were distended. Urine 1014, trace of albumen; no blood. It was thought that the ascites was due to cirrhosis of the liver.

The patient died about a month after admission, and I performed the post-mortem examintion. The right kidney was enlarged, and was irregular and soft on the surface; the whole organ was studded with nodules of growth which had coalesced and undergone softening in the central parts. The right renal veiu and the whole of the inferior vena cava were filled with a firm thrombus. The upper half of the vein was much distended with the thrombus, which appeared to be cancerous. An ante-mortem thrombus was found in the right auricle; it was continuous with the thrombus in the inferior vena cava. The explanation of the symptoms and physical signs is as follows: the hæmaturia and the lumbar pain was the first indication of the carcinoma of the kidney. The swelling and œdema of the legs was caused by the thrombus in the right renal vein extending to and blocking the inferior vena cava. The onset of ascites indicated a spread of the thrombus upwards in the inferior vena cava, with consequent obstruction of the hepatic veins, a condition which produced portal obstruction.

Backward pressure in chronic heart and lung disease.—Ascites from these causes is usually preceded by swelling and œdema of the legs. A careful examination of the heart and lungs, and the detection of valvular disease of the heart, or chronic bronchitis, and emphysema would satisfactorily account for the presence of ascites. It should be remembered that enlargement of the liver also results from these diseases. The enlargement may be considerable; the edge is usually sharp and well-defined, and may reach to the level of the umbilicus in the right nipple line. The surface is smooth; it may be tender, and pulsation may be detected in it. The urine is concentrated and may contain a little albumen.

Bright's disease.—Ascites from this cause is usually associated with general anasarca. A diminution in the daily amount of urine, a high specific gravity, the presence of a large quantity of albumen and blood, and a diminution in the amount of urea, point to acute nephritis. I have already drawn your attention to the fact that ascites in Bright's disease may be due to four different causes. I have also alluded to acute and chronic peritonitis under their respective headings, and have just told you about that form associated with general anasarca, so that only one variety remains for consideration, viz., ascites caused by backward pressure, the result of hypertrophy and dilatation of the heart. This form occurs most frequently with chronic interstitial nephritis, and it may be difficult to distinguish from the ascites caused by primary disease of the heart. Pale urine of low specific gravity, with a trace of albumen, would point to chronic interstitial nephritis, especially if an examination of the eyes showed the presence of albuminuric retinitis, and the arteries were found to be thickened and tortuous.

Ovarian disease.—Ascites may follow rupture of an ovarian cyst, or it may be associated with papilloma of the ovary, secondary papillomatous growths developing in the peritoneum. A few years ago a very familiar figure in Mary ward was a woman, just over thirty years of age, who used to come in sometimes twice a week to be tapped. Altogether paracentesis abdominis was performed two hundred and ninety-nine times between September 20th, 1884, and April 24th, 1893. Occasionally she relieved herself by performing paracentesis with a knitting needle.

At the post-mortem examination two large cauliflower-like masses of papillomatous growth were found on one side of the uterus, that on the right being the larger and reaching as high as the umbilicus. All the pelvic viscera were adherent to each other. The left Fallopian tube was distended. Secondary peritoneal growths were mainly confined to the parietal peritoneum and over the surface of the liver, stomach, and spleen, which were adherent to one another. The peritoneum covering the intestine was almost free from growth. A report of this case by Dr. Pye-Smith will be found in the Path. Soc. Trans. of a few years ago.

I have told you of these different forms of ascites, illustrated them with some cases, and I have endeavoured to show you that the diagnosis of ascites is not so simple as at first sight it may appear to be, but that it is often extremely difficult. By bearing in mind the different points that I have directed your attention to, you may be helped perhaps to make a correct differential diagnosis of the cause of ascites when you come across a patient suffering from this important manifestation of disease.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Bryant for Dr. Taylor.

Philip 27. Myelitis.
29. Aortic disease. Hypertrophied and dilated left ventricle. Indicanuria.
34. Phthisis. Vomica.
35. Malignant disease of pleura. Secondary deposit in kidney.
36. Chronic interstitial nephritis.
37. Hodgkin's disease. ? G.P.I.
38. Phthisis.

Mary 39. Albuminuric retinitis.
40. Fits.
45. Chorea. Arsenical neuritis.
46. Carcinoma ventriculi.
49. Anæmia. ? Addison's disease.
50. Motor aphasia. Optic neuritis.

Cases under Dr. Hale White.

Philip 1. Tonsillitis.
2. ? Growth of thorax.
3. Mitral constriction.
4. Diabetes. Gangrene of toe. Amputation.
5. Pericarditis.
6. Pneumonia.
7. Mitral and tricuspid disease.
10. Diabetes.
12. Tubercular laryngitis.
13. Hemiplegia.
14. Malignant disease of liver.
15. Mitral stenosis and regurgitation. Hæmatemesis.
16. Pericarditis.
18. Aortic disease.
20. Infective endocarditis.

Mary 13. Gastric ulcer.
15. Cerebral tumour. Optic neuritis.
16. Pernicious anæmia.
17. Phthisis.
18. Rheumatic erythema. Dilated heart.
19. Exophthalmic goître.
20. Mitral stenosis and regurgitation.
21. Mitral disease. Pregnancy seven months.
22. Pyonephrosis.
24. Thrombosis of middle cerebral artery, secondary to confinement.

Cot 54. Tubercular peritonitis.

Cases under Dr. Pitt.

Mary 26. Left pleuritic effusion.
27. Marasmus.
28. Thrombosis of right femoral vein.
29. Chronic tubal nephritis.
33. Insular sclerosis.
34. Chronic bronchitis.
35. Mitral stenosis. Tricuspid stenosis. Pulmonary regurgitation.
36. Quiescent phthisis. Tetany. History of hæmatemesis.
37. Abdominal tumour.

Stephen 22. Empyema.
23. Pleuro-pneumonia. Left base.
24. Appendicitis. Operation.
25. Pneumonia. Right base.
26. Tubercular kidney. Operation.
27. Typhoid.
29. Mitral stenosis and incompetence.
30. Typhoid.
31. Pneumonia. Left base.
34. Carcinoma of liver.
37. Hæmoptysis. ? Growth.
39. Chronic interstitial nephritis. Epistaxis.
40. Acute laryngitis.

Cases under Dr. Perry.

Mary 2. Hydronephrosis. Nephrorraphy.
6. ? Uræmia.
7. Pernicious anæmia.
8. Cerebral tumour. ? Gumma.
11. Granular kidney (lead). Aortic stenosis. Mitral regurgitation.

Stephen 9. Basal phthisis. Pleurisy.
15. Tuberculous peritonitis.
16. Mitral stenosis and regurgitation.
19. Fibroid lung.

In the Surgical Wards.

Cases under Mr. Howse.

Astley-Cooper 1. Flap wound in arm.
7. Fractured femur.
18. Crushed hand.
32. Fractured base. Fractured clavicle.

Job 3. Epithelioma linguæ. Operation.
5. Strangulated inguinal hernia. Resection of gut.
6. Varicose veins.
7. Mediastinal abscess.
8. Recurrent epitheliomatous glands under chin.
21. Lymphadenoma. Operation on cervical glands.
23. Osteitis. Periostitis of humerus.

Lydia 2. Fractured neck of femur. Intracapsular.
4. Tuberculous breast. Amputation.
6. Femoral hernia. Radical cure.
8. Strangulated umbilical hernia. Operation.
10. Tubercular dactylitis.

Cot A. Crushed foot.
Cot C. Fractured femur.

Cases under Mr. Lucas.

Astley-Cooper	9.	Fractured 10th and 11th ribs. Hæmaturia. Pleuritic effusion.
	16.	Compound fracture of tibia and fibula (tibia wired.)
	29.	Comminuted fracture. External malleolus.
Lazarus	5.	Tuberculous ankylosis of hip. Abscess.
	16.	Epithelioma recti. Excision.
	17.	? Sarcoma of knee. Amputation.
	20.	Epithelioma penis. Amputation.
Martha	16.	Hallux flexus. Excision first metacarpo-phalangeal joint.
	19.	Tuberculous knee.
	21.	Strangulated femoral hernia.
Cot B.		Bow legs. Rickets.

Cases under Mr. Golding-Bird.

Cornelius	4.	Pott's fracture.
	7.	Ununited fracture of femur.
	20.	Abdominal injury. Hæmaturia.
Luke	5.	Epithelioma of lip.
	6.	Ununited fracture of humerus. Wired.
	10.	Carcinoma of rectum.
	12.	Congenital torticollis.
	13.	Urethral stricture.
	14.	Necrosis of sternum after typhoid.
Charity	1.	Tuberculous elbow. Senile.
	10.	Scoliosis.
	13.	Pirogoff's amputation.
	14.	Fractured femur.
	16.	Renal calculus.
Cot B.		Hare-lip and cleft palate.

Cases under Mr. Jacobson.

Naaman	3.	Osteo-myelitis of upper end of femur.
	4.	Parenchymatous goître. Operation.
	7.	Chondro-sarcoma of left side of chest. Operation.
	8.	Tuberculous knee. Amputation.
Dorcas	7.	Sarcoma of ilium. Operation.
	11.	Fibro-adenoma of breast.
	13.	Hip disease.
Cot C.		Tuberculous knee.
Cornelius	3.	Separation of symphysis pubis.

Cases under Mr. Symonds.

Job	13.	Sarcoma on sacrum. Colotomy.
	14.	Cicatricial stenosis of duodenum.
	15.	Ectopia vesicæ. Operation.
	16.	Gall-stones. Operation.
Lydia	19.	Renal calculus. Pyonephrosis. Nephrectomy.
	20	Biliary fistula.
	22.	Ovarian tumour.
Patience	1.	Mammary abscess.
Cot		Cellulitis of orbit.
Samaritan	11.	Septic wound in arm. Cellulitis. Incision.
Job	18.	Laryngeal stenosis.
	19.	Epithelioma of larynx. Excision.

Cases under Mr. Lane.

Lazarus	13.	Recurrent appendicitis.
Martha	10.	Tuberculous bursitis.
	12.	Talipes equinus.
Samaritan	10.	Acute cellulitis. ? Anthrax.

Cases under Mr. Dunn.

Luke	3.	Œsophageal stricture.
	4.	Inguinal hernia.
Charity	22.	Carcinoma of rectum.
Samaritan	12.	Diabetic gangrene of foot.

Cases under Mr. Fripp.

Naaman	22.	Appendicitis.
Dorcas	21.	Varix of forearm. Operation.
Cot D.		Talipes equino-varus. Operation.
Patience	14.	Varicose ulcer with erysipelas. Operation.

The Anatomy Lectureship.

On Friday, March the 23rd, Mr. Lucas delivered his last lecture as Anatomy Lecturer in the Anatomical Theatre. In bidding farewell to the class Mr. Lucas spoke the following words:—

"I am meeting you here to-day for the last time as a lecturer on anatomy, and I would wish to say a few words of farewell in leaving you to continue in this interesting study. It is a subject which I dearly love, and which I cannot leave without regret; for I early caught my enthusiasm for it from one of the most brilliant teachers this school has ever known. I leave my tribute at his feet. Brilliant meteors fall but seldom; yet we may all by dint of labour contribute something to a general diffusion of light. But the teachers must do more than teach. It is for him to ignite ambition's spark, and fan the glowing embers of genius into fame. Herein lies his greatest power. Some grow great by absorbing the work of others and including it in books without acknowledgment, but the greatest teachers lose themselves in those taught, perhaps to reappear in the generation which follows. The fame of the warrior depends on those fought, the fame of the teacher rests with those taught.

"Here we find a true heredity. Children of men's flesh begotten too oft belie their parentage and revert to some more barbarous ancestry. At best their number is limited, and their influence, of necessity, small. But the offspring of men's intellect are not hedged in by numerals, and their influence may be as wide as the confines of the Universe. I claim you all as my children, and only regret that you have not a more distinguished anatomical parentage.

"The study of anatomy has many advantages. Not only does it qualify you for the performance of the necessary

operations of surgery, but it teaches you to observe and to be exact; and if you wish to test your own memory for exactitude, attempt to depict from memory what you think you know, and then you will soon find how deficient in detail your memory may be.

"Many regard human anatomy as a completed study in which there is no room for further advance, but nothing could be more removed from the truth. Twenty-five years ago not a book in the English language described the normal arrangement of the brachial plexus of nerves correctly, and only quite within the last few years have the abdominal organs been correctly placed and described. Listen to this, from Gray's Anatomy, 1875 edition, in reference to the brain: 'There is no accurate resemblance between the convolutions in different brains, nor are they symmetrical on the two sides of the same brain'; and 'The sulci are generally an inch in depth: they also vary in different brains and in different parts of the same brain.' Fancy that as a description of the convolutions and sulci of the brain! But just as we see so clearly now the mistakes of twenty-five years ago, so twenty-five years hence will anatomists see the mistakes which all now make and teach. The completion of human anatomy will only end with the cessation of the development of the human species.

"But I must not detain you long. In leaving anatomy I feel like a boy taken away from the home in which he was reared; where every nook and cranny is familiar to him; where every tree and flower seems to welcome him; where the rippling brook is music to his ears, and the sighing winds breathe ever hope; where all is kindness, joy and happiness. With such feelings as these I leave you, and such little knowledge as I possess I bequeath to you. May all good fortune attend you, and take this as a parting maxim—*that the use of that of which you are made will determine the future to which you attain.* If any suggestion I have made may have been of service to you; if any word or idea may have assisted your memory or stimulated your thought, in this I gain my reward. Your future success will be my future pleasure. And now to all farewell, and to anatomy farewell. Good-bye, and God bless you all."

A Sleepy Letter.

Sleep, sleep, glorious sleep! So like death, and yet the essence of life. Adversity, the proverb says, brings us strange bed-fellows. Certainly, as we stumble along through life, we find ourselves in many strange beds. I remember, when I was a student, my little "digs" in Maze Pond, for which I paid the magnificent sum of ten and sixpence weekly—one small bedroom (rather like a cupboard, and the size of which made me thankful that an all-seeing Providence had provided me with short legs instead of long ones), and a sitting-room on the same scale.

I remember in still harder-up days occupying a bed-sitting-room at, I think, nine shillings. Jolly times, too. Hard work and plenty of it in the hospital—dear old Guy's—and then some reading for the dreaded finals, and after perhaps a supper of bread and cheese at the "Ship," to bed, and no rocking required to get to sleep.

Jump from this to Venice—sleeping in a bedroom from which the top of St. Marc's could just be seen, overlooking an old stone court with a well in it—Venice, the beloved of the poet, artist, and last, though by no means least, the newly-married couple. To my idea, a honeymoon, to be perfect, should be spent half at Venice and half at Glengarriff, in Ireland.

Some years ago the Special Service Squadron I was then in anchored off Glengarriff for a few days, and the beauty of the place passes description. Situated in a still, half-inland sea, at the head of Bantry Bay, the water studded with dark, green, heavily-wooded, rocky islands, it remains impressed on the mind more as a beautiful dream than the remembrance of a reality. I have waked in my bunk of a morning, and looking through my scuttle, seen portentious Vesuvius sitting like a great guardian, or perhaps threatening, spirit, towering over the lovely Bay of Naples.

Sleep in the heat of the Red Sea is not always easily obtainable. We always spread ourselves out on deck, although in some ships this is not allowed—goodness knows why.

I remember rather a funny incident occurring at Aden one sultry night. I was, as usual, sleeping on deck, and was awakened by a sudden crash. What had happened was this. A lot of ventilators had been stacked in the fo'c'sle for some reason or other, and a sudden gust of wind had blown them down with a tremendous rattle. Down below a cry of "Collision" was raised, and all the men were trying to get up the hatchways, crowding and jumbling together, as a panic-stricken lot of men always do. One of the carpenter's mates, who was obviously more frightened than anyone else, was elbowing his way along in the crowd, shouting out at intervals, "Steady, boys, steady! Let me go first; I'm a married man with five children, and I've got eighteen pound in the bank."

I have slept at Kephissia, in the slopes of Mount Pentelicus, when it was a question as to whether Greece was or was not to be wiped off the face of the globe. I mean just after the Græco-Turkish *fiasco*—I cannot call it war. Let Greece seriously attempt to set her house in order, and for the moment forget her grand old traditions, which in her present state can only be used by excited and self-interested statesmen for their own ends. Let her organise her police and look after her poor. The fustian jacket is honest; it is the black coat which is the cause of her misfortunes.

I have realised that dream of every boy—that is, I have slept in a Sultan's palace. I once had a trip across Zanzibar and slept at Dunga, one of the Sultan of Zanzibar's so-called palaces.

A great big, crumbling, roughly-built structure, black soldiers, black servants, black grooms—certainly an experience, and an interesting one. All around a lovely tropical country; pineapples, cocoanut palms, cloves, mangoes, and much else, all flourishing in a climate which is not far from poisonous to man and horse.

I have gone to bed sweating at every pore off sweltering Spanish ports, and shivering, got under as many blankets as possible in the Orkneys and on the wild west Irish coast, and I've been thankful for a few minutes' breathless sleep in my verandah during a sultry Maltese sirrocco, to be waked all too soon by the almost ceaseless clamour of bells, and the dismal, half-chanted prayer of *dghaisa*-man coming across the harbour.

I have written enough to show what must be the experience of all in the Navy—an experience which I would not have missed for a great deal.

All the same, I must confess that I am right glad to be once again in England, to know that after a good old homely dinner (and perchance a pipe or two and a glass of grog after), I can wrap myself up in good old homely blankets, and snore a good old homely snore.

Home sweet home *is* home sweet home, after all is said and done.

G. S.

Notices.

ARTHUR DURHAM PRIZES FOR DISSECTION.

The Prize for Second Year's Students has been awarded to Mr. A. M. Webber, and Certificates to Messrs. G. Carlisle and F. Rogerson.

The Prize for First Year's Students has been awarded to Mr. E. C. Peers.

TEST EXAMINATION IN PRACTICAL DENTAL METALLURGY, MARCH, 1900.

Pass List.—J. B. Barron, S. Clifford, R. J. Green, W. E. Griffin, C. Mills, W. H. Peatfield, J. F. Rey.

THE LEES AND RAPER MEMORIAL LECTURES.

The Second Lecture will be delivered by Professor Victor Horsley, M.B., F.R.S., in St. James's Hall, Piccadilly, W., on Friday, April 27th, 1900. Subject: "The effect of Alcohol upon the Human Brain." Chair to be taken at 8 p.m., by Augustine Birrell, Esq., Q.C., M.P.

Admission by tickets only, applications for which can now be registered. Tickets for numbered reserved seats will also be issued at One Shilling each.

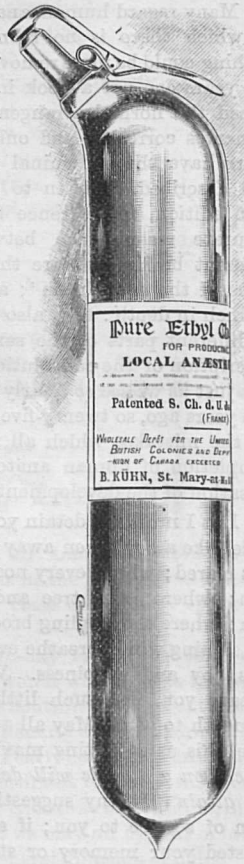
JOHN KEMPSTER,
Hon. Sec. to the Trustees.

Broad Sanctuary Chambers,
20, Tothill Street, Westminster, S.W.

Novelties.

A NEW ETHYL CHLORIDE CONTAINER.

The value of Ethyl Chloride in minor surgery is too well known to need exposition here. Messrs. Kühn have introduced, however, a new container in which the old screw-stopper, with its usual misplacement after use, is replaced by an automatic valve arrangement. The annexed block will show the detail better than a verbal description. The saving in time, which is of the greatest importance in local anæsthesia, and in material is obvious. The issue of the liquid is controlled by pressure of the thumb, and the tube can be immediately laid aside without any delay in finding and affixing the old pattern stopper. The only disadvantage in this new pattern container lies in the liability of the spray to spread and take unwished for paths when the operator unconsciously slackens his grasp on the valve. The remedy for this lies in greater experience on the part of the operator.



CHLORETONE.

This substance has the empiric formula $C_4H_7OCl_3$ and is derivative of a fatty acid. Its position in pharmacy depends on its hypnotic, analgesic and anæsthetic properties, and on the fact that its action as a cardiac depressant is practically negligible. It may be given either by the mouth in doses of from six to eighteen grains when intended as a sedative or hypnotic, or as a local anæsthetic by Schleich's infiltration method, using for this purpose a saturated warm solution of the drug. A third use, and one which we have found to be the most valuable application of Chloretone, is its employment in painful dressings. If possible, the part is submerged in the solution and the dressing performed while the wound is actually in contact with the anæsthetic. In other cases free bathing is resorted to, with good results. On the whole, this substance should prove a useful addition to the list of minor anæsthetics, especially in private practice.

Passim.

The subscription list for the R.A.M.C. Comforts Fund is growing very slowly; much more slowly than we could wish when the excellent object is taken into consideration. Many of our readers have no doubt given to the fund through the agency of the *Lancet* and *B.M.J.*, but, on the other hand, there must be many whose pockets are as yet untouched. To them we appeal for the modest half-crown. May it not be in vain!

In the last issue of the Gazette we briefly recorded the Assault-at-Arms in the Pavy Gymnasium. A full account of this entertainment will be found in another column; here it will suffice to give one or two of the factors which went towards making the evening a success. Firstly, a feeling of completeness was induced when Dr. Pavy took the chair. It is peculiarly fitting that every meeting held in the Gymnasium which Guy's owes to his generosity, should be under the presidency of Dr. Pavy, and when we consider the numerous ties and engagements which occupy his time, it is deeply gratifying to the men who are responsible for these entertainments to find that Dr. Pavy invariably considers his engagement with us of supreme importance, and has never yet disappointed us when he has once promised to attend. A second factor lay in the presence of a number of the Staff, and thirdly, the evening owed much to the kindly help of Captain Hutton and Mr. Barton Wright. And it reflects credit on the newly-revived Fencing Club that such a renowned and fully-qualified critic as Captain Hutton should have expressed his opinion that the fencing was "good."

We have received an advance copy of the "Hand-Book of the Clinical Research Association." Although this Association was founded over six years ago, and now numbers on its membership roll two hundred and thirty public bodies and over three thousand private practitioners, there is still a considerable amount of ignorance with regard to its functions, even among the alumni of the school to which it owes its existence. Briefly, the object of the Association is to assist Medical Practitioners, Sanitary Authorities, and other Public Bodies in the prevention, diagnosis, and treatment of disease, and in the investigation of the causes, progress, and termination of morbid processes, whenever help to this end may be gained by accurate reports on the result of microscopical, chemical or bacteriological examinations. It must have struck everyone who has held an appointment at this Hospital, that his future work, when in private practice, would lack the support and help which the numerous scientific departments lend the Hospital Staff. It is here that the Clinical Research Association steps in, and brings the methods of scientific diagnosis within the reach of everyone who chooses to avail himself of his opportunities.

We publish in another column an interesting extract from a letter home by Surgeon Beadnell, R.N. As, no doubt, most people will remember, this gallant officer was one of the historic naval brigade landed from H.M.S. Powerful at the outbreak of the war. His record is a brilliant one. In action at Belmont, Graspan, Modder River and Maggersfontein, he was one of the relieving column at Kimberley, and again was in the action at Paardeburg with the subsequent triumphal march to Bloemfontein. As he has now been attached to the staff of the Commander-in-Chief there is every reason to suppose that he will put the keystone to his "arc de triomphe" by assisting in the capture of Pretoria. We wish him good health and plenty of Boer patients.

A correspondent has sent us an extract from the published letters of Miss Holroyd, afterwards the wife of the first Lord Stanley of Alderley, which gives a gruesome, though comic, description of the accommodation of Guy's Hospital at the end of the last century. The writer was a granddaughter of Lewis Way, one time president of Guy's Hospital. The ward to which she refers is now the Clinical building, which is shown in old plans as the "ward for lunaticks":—"Papa has got into Guy's Hospital some Frenchmen, gentlemen and officers, who, perhaps, you may recollect something of them having been a long time confined on board a ship, and at last escaped by swimming to shore; I forget the particulars. How melancholy to think that these gentlemen are most thankful for admittance to the hospital! But one of them, a very genteel young man, is almost eat up by the 'itch,' and as it is a very extraordinary complaint, and they had no other proper place to put him into, he is now in the same apartment with the lunatics."

One of the Clinicals required the family history and previous medical history of a small child in John ward. The child's evidence was obviously of no value, so with commendable keenness the clinical wrote in order to arrange an interview with the child's father; failing this he asked for the usual particulars which go to make up a report. In return he received the following letter: "Kind Sir, I am very sorry I cannot come at 10 a.m. as I am at work I beg to state my wife died with dropsey and congension of the lungs my little son Benjamin was Born at Nunhead Ivydale Rd on 19 November 1893 I do not know where he was christened as I was away from Home his Bowels were open on Tuesday 13 March for first time since Saturday Religion Church of England. I am Sirs, Your Most Obedt. Servt.——." As a matter of fact the bed-letter shows that his bowels were non-conformists.

At the last session of the Physical Society, a resolution was passed expressing regret that reports of its proceedings had not latterly appeared in the Gazette, and asking for an explanation of this circumstance. The reason is quite obvious. No reports had been sent in. For our part we regret, with the Physical Society, that opportunity has not been given us to publish several excellent papers that have been read since Christmas last. We hope that the action of the Physical Society will have the desired effect in unearthing the authors from their modest retirement. One paper, indeed, was in hand at the time of the motion, but nevertheless only good can come of a general feeling expressed at a public meeting, that authors of papers read before this society must not rest content on the laurels achieved at a single session, but must hand down their labours to posterity in the columns of the Gazette. We thank the members of the Physical Society for their undoubted sympathy with us which prompted them to frame and pass this resolution.

A letter has been received which we are unable to publish, as we do not think such publication would subserve the best interests of the hospital. The writer, a student of this hospital, whose experience as yet is confined to the dissecting-room, makes a severe attack on the administration of the hospital, based on "facts" supplied by a friend. He admits his evidence to be merely hearsay evidence; he makes no attempt at analysis, nor does he even concern himself with a superficial verification of his statements. The person on whose behalf he brings these charges "becoming seriously unwell" consults a medical man "who is hopelessly incapable." Dissatisfied with his diagnosis, he comes to the front surgery where he is received "by a student who made a show of examining him"—here is the keen analytic mind again—"keeping up a running fire of idiotic observations." The student then asks him to wait until his return, and goes off to fetch the house-physician to the case. This is our own interpretation of the statement. Meanwhile, however, this rare thinker, whose brain penetrates the superficialities of the medical man and probes the depths of the student's ignorance in physical examination, seeks further advice of a policeman, and goes off to find a "decent practitioner" in the Borough! And here the story ends; but we should dearly like to hear the sequel from the "decent practitioner."

Two letters received from South Africa, from members of the Nursing Staff, give a very excellent idea of the work done by an Army Sister on active service. Our medical correspondent at Wynberg has given a technical, expert view of Army Medical matters; our nursing correspondents supply the necessary details to render the picture perfect. Sister Lilian, writing from No. 2 General Hospital, says:—"On Thursday . . . we saw our hospital . . . ours is all under canvas. There are about a hundred tents pitched in lines of six. . . . We go on duty at 8.30 a.m., and have charge of eight tents, each containing six beds. During the morning we go round and see the patients, take temperatures, give medicines, etc., then go round with the M. O. in charge, and help with any dressings. We go off duty at one for lunch, and if there is nothing to do stay off till five, except the orderly sister, who is on duty all day. We go off in the evening at eight, and so far we have been quite ready to go, for though the work is absurdly light just now, there is a great deal of walking from tent to tent, and the uneven ground tires one very much." Apparently the Colonists spoil both the patients and Sisters, for Sister Lilian says the men have everything they can wish for, eggs, milk, fruit, flowers, books, tobacco, etc., while Sister Martha also comments on the extreme generosity of the residents of Wynberg, and gives most provoking descriptions of numerous luscious fruits. Apparently one can do worse than go to Wynberg.

The Debating Society cannot be congratulated on the success of its ladies' night. Of late days we have become accustomed to such a high standard of excellence from this Society that any degradation to the level of mediocrity comes as a most unpleasant surprise. In numbers, perhaps, the meeting was successful. The Court-room, for which the Society was indebted to the Governors, made a stately though unfamiliar House, and it is just possible that the uncongeniality of the surroundings found its echo in the speeches of the members. At any rate, the general characteristic of the speeches was dull, prosy verbosity. Mr. Wacher stands out as a brilliant exception; his speech, though short, was bubbling with mirth, and in his bold defence of shameless vice Mr. Wacher seemed as if he were going to thrash some spark of liveliness into the House. But almost immediately the glow flickered and was not, and the discussion jogged on in the insipid monotony of effeteness. Mr. Shufflebotham by pleasantry and Mr. Thompson by judicious insult, sought to stir the House, but both alike failed and the meeting ended, like the Pathetic Symphony, "in unutterable gloom."

It was pleasant to see Goddard turning out to play against the London Irish on St. Patrick's Day, although he apparently did not find it so. Though "fat, and scant of breath," he played the same keen game as of old. Shorland, Featherstone, Gibson, Hilton and Pinching were also members of the "old brigade," and though untrained, managed to keep going, while Featherstone played one of the best games on the ground. McEvedy, a centre-threequarter of whom we hope to see more of in the future, was also good in the attack, and Harrison was very sound in his kicking and defence. The game struck an outsider as being of a somewhat conversational kind, but was, on the whole, marked by the best of temper. It was noticed that when one or two of the home side were brought down, a distinct succussion splash could be heard.

In the semi-final round of the Surrey Cup competition the Second Fifteen found a decidedly superior team in Sutton, and were somewhat outclassed, especially forward; they, however, made a game fight for it, and are to be congratulated on reaching such a stage in the Cup ties. The tackling done by Bridger at full-back was a noticeable feature in the game, and he only wants to be a bit quicker to be first rate in this position. There was a fair attendance at Honor Oak Park, including several of the Junior Staff and Residents.

We hear that the telephone service of the hospital is to undergo complete reorganization. The various wards and departments at present unconnected will each have their proper instruments and will all communicate with a central exchange. All the present instruments will be replaced by some one modern pattern, and with the disappearance of heterogeneity a great deal of the discomfort at present attached to the use of the telephone will vanish. At present we are in a late stage of a constructive process. To the original two or three points, others have been added, and naturally with every addition there has been some modification in pattern of the instrument, marking the progress of the industry. Hence we have now every variety of telephone, including one or two obsolete patterns, in use in the hospital, and hence, also, the continual difficulty in reconciling the working of one transmitter to that of another receiver. And with an extension of the telephone service will come increased familiarity with the usage of the instruments which is in itself no mean factor in the successful working of a system.

There has been much thinking of gigantic thoughts in the vain desire to solve what may be termed the Front Surgery problem. The kernel of the conundrum lies in the standing order that every patient must be seen by the House-Surgeon or Physician on duty in the Front. Given this condition, the puzzle is to find out the best means of obeying the order. There are two methods of tackling the problem. In the one, the two factors, Dressers and Clinicals are considered as negligible quantities; in the other they are considered as independent variables of the first (M.B.) degree, and since a solution of the problem in this aspect requires a knowledge of Very High Mathematics, with a dash of Metaphysics, it is left severely alone. We have received several answers more or less ingenious, but still hardly applicable. One suggestion is that the Duly Qualified Man should sit in a little room and examine every patient before he is admitted to the surgery; a second carries the idea still further and introduces a turnstile and tickets—an obvious plagiarism on the Electric Railway; a third gives the D.Q.M. little flag-labels,

patriotic or otherwise, which he must attach to each patient when seen. Finally, there is the suggestion that the Porter at the Front Lodge should be a qualified man and see every patient before admission to the Hospital. Certainly he enjoys an unique observational position.

The Pupil in Health and Disease.

A Paper read before the Physical Society on Saturday, January 20th, 1900, by Mr. C. T. Hilton.

Mr. President and Gentlemen,—I should like to first call your attention to a few points in the anatomy and physiology of the pupil.

Development.—The primitive ocular vesicle is invaginated by the lens to form a double walled cup, which is called the secondary ocular vesicle. The inner layer forms the retina, the outer the pigmented epithelium, which lies external to the rods and cones. Where these two layers are continuous in front corresponds to the margin of the pupil in the fully-developed eye. Round the lens (fig. I) is formed a vascular network derived from

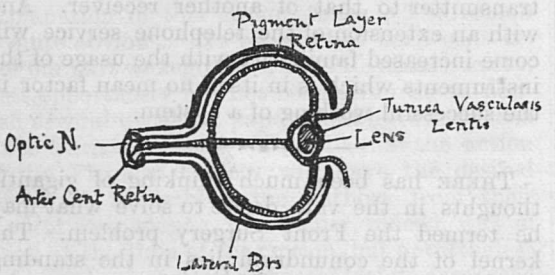


Fig. I.

the central artery of the vitreous, from its lateral branches which run over the retina, and from arteries from outside which come in over the edge of the cup, and are derived from those which eventually form the circulus iridis minor. This vascular membrane round the lens is called the tunica vasculosa lentis, and that part of it which occupies the position of the pupil forms the papillary membrane. This membrane should disappear in the last two months of fœtal life; occasionally it or parts of it persist after birth. Mesoblast also assists in forming the iris, the two layers of the secondary ocular vesicle being pigmented and united to form the pigmented part of the iris.

Anatomy.—The iris is so called because of its rainbow shape, not on acccunt of its colour. Its free inner edge forms the margin of the pupil. The pupil was probably so called from *pupilla*, a girl, perhaps because the image can be seen in it. In old German books it was called Kindlein—a little girl—and in Greek κόρη—a girl. It lies a little to the inner side of the centre of the iris, its size varying from 1 to 8 m.m. The muscle of the iris is of the non-striated variety. Some observers deny the presence of a dilator pupillæ, and say that what appears to be the dilator is really a posterior limiting membrane, which acts as a dilator by elastic traction. The nerves in the iris are derived from the ciliary nerves and become non-medullated before they are distributed to the muscles and vessels.

The pupillary centres and their connections and course of fibres—The pupil centre is situated in the third nerve nucleus below the corpora quadrigemina. The nucleus is a complicated one as may be seen from the diagram. (Fig. II). It receives fibres from the sixth nerve nucleus

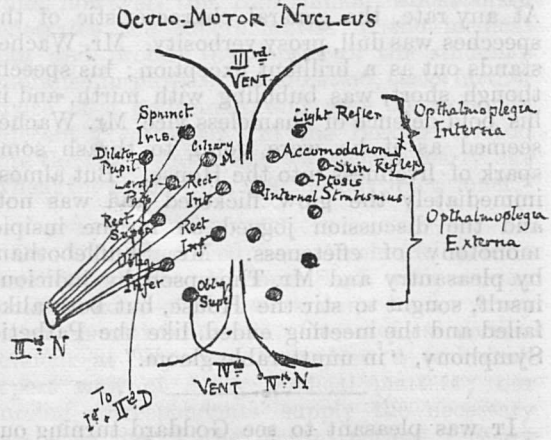


Fig. II.

of the opposite side through the posterior longitudinal bundle. There are commissural fibres between the two third nerve nuclei, and some fibres of each nerve arise from the opposite side. The nucleus for the fourth nerve lies below under the inferior corpora quadrigemina. The third nerve nucleus has fibres connecting it with the corpus quadrigeminum superius, and these pass up to it in close relation with fibres of the fillet, coming from the cells of the posterior cornu of the cord and its terminal nuclei, and passing up between the third nerve nucleus and the corpus quadrigeminum superius, and going to the subthalamic region, some of these fibres passing up to the corpus quadrigeminum superius. The corpus quadrigeminum superius in its superficial layers contains retinal nerve-fibres, which reach it through the lateral root and superior brachium of the optic tract. The deeper layers contain retinal fibres, and fibres through the optic radiations from the occipital cortex. In the deepest layers are fibres derived from the fillet and from the oculo-motor nucleus.

In the optic nerve there are a number of small fine fibres different to the true optic fibres, and these are supposed to pass directly to the oculomotor nucleus, and serve as a medium for conveying the impulse for the light reflex of the pupil. This bundle of fibres occu pie a dorsal position in the optic tract, and probably arise from cells in the corpus quadrig. superius. Bechterew says they pass from the posterior border of the optic

chiasma into the grey matter around the third ventricle and thence direct to the third nerve nucleus. The clinico-pathological observations of Moeli and Henschen tend to confirm this. But it is impossible to believe that all take this course because of the hemiopic pupillary reaction. Darkschewitsch and Mendel say the fibres leave the optic tract in the region of the external geniculate body and pass to the ganglion habenulæ and from there by the posterior commissure to the nucleus of the opposite third nerve. Ramon y Cajal and Köllicker say the fibres leave the tract and end in cells in the superficial layers of the corp. quad. super., which cells send protoplasmic processes and collaterals to the nucleus of the third nerve. This is in accord with Meynert's original statement, and in support of it Ross records a case of tabes dorsalis with loss of light reflex and degeneration of Meynert's bundle.

Stilling says that the optic tract sends a prolongation directly into the outer part of the crus cerebri, which contains fibres which pass to the oculo-motor nuclei, perhaps the above-mentioned pupillary fibres. Though clinically there is a direct and crossed connection between the oculo-motor nucleus and the optic centres in the cortex, there is no anatomical proof as yet. Fibres from the third nerve nucleus and from the posterior longitudinal bundle pass in the posterior commissure to the root of the pineal body on the opposite side ; it does not appear clear what use these are now, but possibly it is a relic of the time when the pineal body was an active eye, and it is not too much to suppose was connected with the oculo-motor nucleus. The oculo-motor nucleus may be connected with the occipital cortex through the posterior commissure and by the posterior longitudinal bundle. This posterior longitudinal bundle serves as a means of communication between the sixth and third and fourth nuclei. It receives fibres from the middle peduncle of the cerebellum which go to the third, fourth and sixth nuclei. Some fibres also pass from it to the corpora quadrigemina, some to the subthalamic region and possibly to the substantia interansalia, and possibly into the optic radiations, and so to the occipital cortex. (Fig. II.) The actual nucleus itself consists of several sets of cells. The anterior nucleus contains the centres for the papillary muscles. The centre for the sphincter iridis and light reflex is in front and to the outer side, the centre for the ciliary muscle and associated action of the pupil being behind and nearer the middle line. The centre for the reflex dilatation after stimulation of the skin is situated slightly behind and to the outer side of these two centres. Behind these come the centres for the levator palpebræ, superior rectus and inferior oblique on the outer side from before back and the internal rectus and inferior rectus nearer the middle line.

The third nerve arises by several bundles, one from each group of cells, some fibres coming from the cells of the opposite nucleus, and these are probably the ones which convey stimuli in the associated movements of the two eyes. The dilator fibres start from the centre, which lies to the outer side and behind that for the light reflex and accomodation centres, and run down the cord through the Pons Varolii, substantia gelatinosa of Rolando and lateral columns of the cord; they probably pass through a subsidiary centre in the cervical enlargement, and pass out of the cord, Quain states, with the first to third dorsal spinal nerves, but other observers have stated that they pass out with the last two cervical and upper six dorsal nerves. Some of these dilator fibres are said to pass into the fifth nerve and to run in the ophthalmic division to the lenticular ganglion. After leaving the cord the dilator pupillæ fibres and also vasomotor nerves run up in the cervical sympathetic and through the carotid plexuses and enter the ciliary ganglion, often journeying with the ophthalmic division of the fifth and running in the branch from it to the ganglion.

The blood-supply to the third nerve nucleus is derived from the posterior cerebrals, which send branches to both the anterior and posterior parts of the nucleus, and from the superior cerebellar, which sends a branch to the posterior part of the nucleus. The hinder part of the nucleus thus seems to be better supplied than the anterior, and this is interesting in relation with Dr. Pitt's theory as to the loss of the light reflex in locomotor ataxy. The centres for the external muscles of accommodation and attraction are thus better supplied than that for the light reflex.

The physiology of the pupil.—About one hundred and seventy years ago, Petit, experimenting upon dogs, found that division of the vagus and sympathetic in the neck produced marked contraction of pupil, ptosis, redness of conjunctiva, etc. Other observers followed, and their experiments showed that division of the cervical sympathetic caused, (*a*) contraction of pupil, (*b*) inward rolling of eye, (*c*) partial ptosis. Valentin showed two sets of nerve fibres to the iris from the third nerve and sympathetic. Budge and Waller showed that the sympathetic fibres came from the spinal cord through the spinal nerves, and found a centre for them in the spinal cord from the sixth cervical to the fourth dorsal, and called this the "cilio-spinal" region. Budge thought that the fifth nerve contained motor fibres to the iris, for the pupil contracted on dividing it even when the third nerve was also divided. Brown-Sequard and Bernard also found that on stimulating the upper end of the cut sympathetic they got dilatation of the pupil, contracted vessels, etc. Professor Reid found that pressure on the cervical sympathetic produced contraction of the pupil whilst applied. Ogle thought that the action of the sympathetic on the iris might be due to its influence on the blood-vessels. It has been shown by numerous observers, both experimentally and pathologically, that division of the third nerve produces loss of light reflex and a dilated pupil, and that stimulation of it gives rise to a contracted pupil. Spallitta and Consiglio state that stimulation of the third and fourth at their origin does not produce contraction of the pupil, whilst stimulation in the cavernous sinus does, and this they said was due to the stimulation of the ophthalmic branch of the fifth

nerve at the same time. They found that the myosis following division of the fifth nerve is due to paralysis of vaso-constrictors and slight excitation of vaso-dilators; while myosis from stimulation of it is due to excitation of vaso-dilator fibres, which produces greater effects than stimulation of the vaso-constrictors. The pupil acts as a means of communication between the anterior and posterior chambers of the eye, as well as an aperture for the transmission of light into the eye.

The lymphatics of the eye.—The most important are the anterior. The aqueous humour is secreted by the ciliary processes. It is not a mere exudation, for it contains very little albumen. It is a secretion in the production of which both the pigmented and non-pigmented layers of epithelium of the pars ciliaris retinæ take place. In the flat part of the ciliary body numerous gland-like processes of the pigmented epithelium are given off, which, in bleached specimens are seen to consist of a single layer of cells with a central lumen. These are found also in some animals as well as in man, and these probably play an important part in the secretion of the aqueous humour. After puncture of the anterior chamber the aqueous humour is secreted much more rapidly because the tension is reduced and the ciliary vessels fill up. But this contains more albumen, and is more in the nature of an inflammatory effusion. The aqueous humour passes from the posterior to the anterior and out through the ligamentum pectinatum into the canal of Schlemm.

Reflexes of the pupil.

The light reflex.—The path of this is through the optic nerve and tract to the corp. quadrigem superius, and from this to the anterior part of the oculo-motor nucleus. There are probably two parts to this centre, a sphincter contraction centre and a sphincter inhibition centre. A lesion of the sphincter inhibitory centre or the fibres arising from it produces a contracted pupil. If fibre going to the centre only be involved, the light reflex is abolished; if both afferent fibres and centre are diseased, we get a contracted Argyle-Robertson pupil. Interference with the sphincter contraction centre causes Argyle-Robertson pupil. Accommodation contraction is retained in both cases by its special centre. The centre is closely connected with that for reflex dilatation of pupil through the sympathetic. Both pupils react to light, even if only one eye be stimulated, and both react to the same extent. But the amount of contraction depends on the sum total of the light received into the eyes, so that if at first only one eye be stimulated and the amount of contraction noted in the shaded one, and then if this also be exposed to the light it will undergo a further contraction.

Sensory reflex.—The path for this is by any sensory nerve through the spinal cord to the centre which lies just outside and posterior to the light reflex centre. The impulses then pass out down the pons varolii, through the substantia gelatinosa of Rolando, lateral columns of the cord, gain connection with a centre in the cervical enlargement, and pass out along the spinal nerves; they then pass up in the cervical sympathetic, join the ophthalmic division of the fifth, and pass with its branches to the ciliary ganglion and iris. Some of the dilator fibres pass out directly with the fifth nerve, for if it be divided the pupil contracts. Some of the dilating effect may be due to vasomotor changes, for the cervical sympathetic contains vasomotor fibres for the vessels of the iris. Contraction of the vessels produces a dilated pupil, whilst dilatation gives a contracted pupil. But that the dilatation is not wholly due to this cause is shown by the fact that stimulation of the sympathetic produces dilatation of the pupil in a bloodless eye. Pressure on the cord in the cervical region so as to interfere with the passage of impulses down the sympathetic fibres will cause the pupil at that side to be smaller.

The pupils reflexly dilate whenever and wherever a sensory stimulus is applied. Hence, in deep sleep and deep narcosis the pupils are contracted, dilating again on the subject waking up, even though he be exposed to the light. Strong psychical stimuli, such as fright, will also produce dilatation of the pupil.

Associated action of pupil.—This is always a contraction. It occurs (i.) in convergence, (ii.) in accommodation.

(i.) The centre for the contraction of the pupil with convergence is in close relation with the centre for the associated action of the internal recti.

(ii.) In accommodation the iris acts with the ciliary muscle. Under physiological conditions accommodation is accompanied by convergence; therefore, we get all the muscles supplied by the third nerve acting together. Gifford noted in some cases, especially those associated with blindness, that on forced contraction of lids, *i.e.*, against pressure of an eye speculum, a contraction of the pupil takes place with the normal upward movement of the globe. It appears that this reaction occurs independently of convergence or accommodation, and points to a close relation between the centres for contraction of the pupil and for closure of the lids. Some fibres of the third nerve may pass direct to the palpebral portion of the orbicularis by the supra-orbital branch of the fifth nerve reaching it through the posterior longitudinal bundle.

The normal pupil is due to the antagonism of the third nerve and sympathetic, the muscles of the iris being in a tonic state of contraction. Mechanical causes help to maintain the size of the normal pupil, for if the aqueous be removed the pupil contracts, therefore pressure in the anterior chamber helps to keep it slightly dilated. This occurs in a dead subject, so is not due to any reflex venous action. The pupils may be unequal if there is a great difference in acuity of vision or in refraction. They react together and equally, and any irregularity is almost always a pathological phenomenon. Physiologically, inequality of pupils may be constant, transient, or intermittent; the last two may be functional. Constant inequality is congenital, and is independent of difference in acuity of vision, corneal lesions, cranial, or facial asymmetry. Its frequency appears to

be over one per cent., and the left pupil is oftenest dilated. The mean width of the pupil varies with age. It is very contracted in new-born infants, but soon becomes more dilated, then smaller again in adult life, and still smaller in old age. In old people, also, the reaction of the pupil becomes more sluggish in consequence of the unyielding nature of the tissue of the iris, especially of the sphincter, the so-called rigidity of the sphincter iridis.

The pupils in sleep.—The pupils are contracted in sleep and the eyes are rolled upwards and inwards. Mosso thinks this due to congestion of cerebral vessels and those of the iris; Durham, however, has shown that the cerebral vessels are empty during sleep. The pupils do not react to light but dilate on applying any sensory stimulus and rapidly also on waking the subject, and this even when light is still falling upon the eye. Ellis thinks this contraction is due to the sphincter being stronger than the dilator, no stimuli reaching the centre. Foster, on the other hand, thinks that sleep cannot be merely a loss of afferent impulses, for then, the retina being quiescent, the pupils should dilate; probably, he thinks, it is due to the continuous action of the mid-brain. Rosenbach, however, seems to regard the contraction as reflex. This condition of the pupils and their reaction to sensory stimuli and light is a good and true test for malingerers.

Reactions of Pupil to Poisons.

Opium.—Dr. Kinnis, in 1818, was the first to notice the fixed, minutely contracted pupils in opium poisoning. The pupils are minutely contracted and insensitive to light and skin reflex, but when progressing towards a fatal termination may be found dilated. The action of opium on the pupil is due to a stimulation of the sphincter contraction centre, and probably a paralysis of the dilator centre. The pupils are too small to be merely the result of paralysis of the centres and the tonic contraction of the sphincter. Alcock thinks that the contracted pupil is caused by paralysis of the sympathetic fibres, and to paralysis of the vasomotor nerves giving rise to dilatation of the capillaries of the iris and so producing contraction of the pupil. Fixed, minutely contracted pupils are not absolutely diagnostic of opium poisoning, for in pontine hæmorrhage the pupils may present the same appearance, but in this case they may be unequal. In carbolic acid poisoning also the pupils are contracted, and there is coma and stertorous breathing, but they are not so minutely contracted, and an odour of carbolic can generally be detected in the breath, and there are often whitish stains about the mouth and lips.

Atropine produces widely dilated pupils. It acts in two ways—(i.) by paralysing the ends of the third nerve in the eyeball, and so paralysing both the sphincter and ciliary muscles, (ii.) by stimulating the ends of the sympathetic fibres, and so causing contraction of the dilator muscle. The effect begins in ten to fifteen minutes and soon reaches a maximum, but only begins to decrease on the third day, but is not entirely gone for about a week. When taken internally both pupils will be dilated and paralysed, there will also be dryness of throat and mouth, flushing of face, acceleration of pulse and perhaps delirium.

Eserine puts the sphincter iridis and ciliary muscle in a state of tonic contraction, producing a condition of pin-point pupil, and accommodation for near objects. It produces a feeling of tension in the eye and often headache and nausea. *Pilocarpine* produces the same state of pupil but without the unpleasant effects. Its action is of shorter duration than that of atropine and is not so powerful, for atropine will dilate the eserine pupil but the reverse action does not hold. It acts by stimulating the ends of the third nerve locally.

Cocaine stimulates the ends of the sympathetic fibres and so produces contraction of the dilator pupillæ, and contracts the vessels, thus causing dilatation of the pupil. The pupil still reacts to light, and atropine and eserine retain their powers. It causes further dilatation in an atropine pupil. The power of accommodation is weakened but not lost. The cornea is rendered insensitive.

Prussic Acid.—In poisoning by prussic acid the pupils are dilated and insensitive to light.

Alcoholic poisoning.—The pupils are usually dilated and fixed, but may sometimes be small, though never "pin-point." If they react to light it is a favourable sign. Macewen says coma may be distinguished by the fact that if patient be left for twenty minutes pupils are pin-point. If you arouse patient by pulling his hair, etc., the pupils slowly dilate to full extent, though he remains comatose, if again left, pupils after a time slowly contract (5–10 mins.). If near a fatal issue they dilate and become fixed.

Strychnine.—In some cases it has been noted that the pupils during the paroxysms are dilated, while in the intermissions they are contracted.

(*To be continued*).

Royal Army Medical Corps.

"COMFORTS FUND."

The following are in addition to the list previously rendered:—

	£	s.	d.
J. M. T., Retford	0	5	0
Dr. W. F. Clarke	0	10	6
Dr. W. J. Henson	0	2	6
Dr. J. W. H. Eyre...	0	7	6

Papers by Guy's Men.

With Dr. Hale White in the Wards of Guy's Hospital. —*Clinical Journal.*

Roentgen Ray Anatomy and Normal Abnormalities. By Edward W. H. Shenton, L.R.C.P. Lond., M.R.C.S.—*The Physician and Surgeon*, No. 3.

The War in Africa.

(From a Special Correspondent.)

H.M. Sick Transport, Spartan,
Durban, Natal,
February 26th, 1900.

In redemption of my promise in my last letter, I will endeavour to give a short account of the journeys of the Spartan from Durban to Capetown, with the wounded sent down from the front after the battles of Elandslaagte, Colenso and Spion Kop. When we arrived at Capetown on November 3rd, we found that some wounded had already been sent from Durban by the Jelunga, and that many more were waiting in Natal. We coaled at Capetown, and in twenty-four hours were on our way to Durban. We had a very rough time off Cape Aqulhas. The sea here is very often dirty, the huge rollers being called "Cape Combers." We had the fiddles on the tables for the first time since leaving England. In the night it was impossible to sleep, as the ship was rolling so. The next morning the weather was so rough that when I was dressing I nearly got thrown out of my cabin into the alleyway. The scenery up the coast is very beautiful. Between Capetown and Cape Aqulhas it is very grand and rugged. Further up, beyond Port Alfred, it becomes very much changed. Instead of huge masses of beetling cliff and rugged rocky coast, a park-like veldt runs down to the sea—wide rolling downs of beautiful green turf, which remind one of the scenery of Devonshire. Another feature which also reminds one of Devon is the rich red colour of the soil in places where it is bare of vegetation. The country rises in series of plateaux, one above another, these gradually mounting to the sky-line. They are really a repetition of Table Mountain—there are many "table mountains" in the country.

Durban is 793 miles from Capetown, and is about three days' sail from Capetown by the Spartan. There is a current running from the channel between Madagascar and the mainland of East Africa—the well-known Aqulhas current—which runs with an average speed of three miles an hour towards Cape Aqulhas, the most southerly point of the African continent. The meridian of Cape Aqulhas (20° E.) is that adopted as the dividing line between the Atlantic and Indian Oceans. The temperature of the water in the Aqulhas current is 70° F. After having one's bath in this water for days together, the cold water in Table Bay, the temperature being only about 54° F., is quite invigorating. This low temperature is due to the presence of a current from the Antarctic Ocean.

We arrived at Durban to find such a heavy sea running that it was impossible for us to cross the bar, and we lay in the anchorage for four days, the ship rolling so much that it was impossible to do anything but hold on. For three nights it was impossible to sleep, the ship rolled so much. The fourth day we were taken into the harbour, much to our relief. We found H.M.S. Terrible and several other cruisers lying in the anchorage. Captain Scott, of the Terrible, as you know, is Commandant of Durban, which is under martial law, and has so been since the end of October. Durban was fortified in November. Guns from the Terrible and other British men-of-war lying here were mounted on the heights around the town. For a short time the town was in a state of panic, the Boers being expected down every day. The relief of the Durbanites can be imagined when the reinforcements from England arrived. Such a welcome never troops had as did the British troops who landed in Durban in November, 1899. Such active, generous, warm-hearted loyalty none of us had ever seen or dreamed of; and it was fully appreciated by the voyage-sick troops. Presents of bread, bananas, tobacco were showered upon them, and these were eagerly received.

On November 11th, we received our first contingent of wounded from Ladysmith. They were sent down from Ladysmith to Pietermaritzburg, and from there were transferred to Durban Most of these were gunshot wounds, chiefly of the limbs. One man was wounded through the head, the bullet entering at the left temple, passing through the skull, and coming out about two and a half inches behind the left ear. It was found necessary to trephine this man, and some necrosed bone was removed. He has done well, and has since been sent to England. Another man had a gunshot wound of the abdomen; the bullet entered half an inch above the pubic symphysis, and passed out through the right buttock, one inch from mid-line. With the exception of some swelling in the right groin, over the external abdominal ring, there was no symptom of any importance. These men were all wounded at Elandslaagte. In a rough analysis of these cases, under my own care of twenty-five gunshot wounds, there were—

Gunshot wound of—			
Head			2
Upper extremity—			
Shoulder	2		
Arm	1		
Forearm	2		
Hand	2		
	—		7
Thorax			1
Abdomen			3
Lower extremity—			
Thigh	7		
Leg	4		
	—		11
Wound of back, not involving spine			1
			—
			25

This analysis is not of much account, but gives a rough idea of proportion of parts hit. Gunshot wounds through the abdomen are almost universally fatal, owing to the impossibility of immediate operation; some cases, however, as the one quoted above (where

apparently there is no wound of the intestine, or if there is, the wound made by a mauser bullet being so small, the intestine has sealed itself), do wonderfully well.

I should like to take this opportunity of thanking Mr. Jacobson for the great assistance I have received from his inexhaustible book, the "Operations of Surgery"; without it I should many times have been far out of my depth.

On November 27th, we had another batch of men down from the front who had been wounded at Estcourt and Willow Grange. These wounds were similar to those we had had after Elandslaagte. With these we sailed for Capetown, which we reached after a fair voyage on December 1st, and disembarked our sick and wounded into the hospital train for the Base Hospital at Wynberg and Rondebosch. When we were disembarking two men were seized by the sentries, Boer spies both (*arcades ambo*). They were trying to get information from the wounded as to our casualties. After we had disembarked our sick cargo, we left the dock, and immediately sailed for Durban. Of the wounded from the terrible battle of Colenso I will endeavour to speak later. S. E. D.

The following is an extract of a letter from Surgeon Beadnell, H.M.S. Powerful, written from Paardeburg Drift, Modder River, February 24th.

"We, the Naval Brigade, left Modder River Station, February 17th, 10 a.m., with two 12-pounder guns, and arrived at Jacobsdal 2.30 p.m. We slept there the night and trekked to Klip Kraal the following day, starting at 10 p.m. in the dark and arrived 6 a.m. dead beat. My horse is dead, so that I had to march the whole way. On arrival had a swim in the Modder River and breakfast (?) after; trekked again at 2 p.m. and arrived Stockfontein 10 p.m., fairly tired out and frightfully hungry. Slept here; started again 10 a.m. and arrived Paardeburg at noon, February 20th. Took up position at once and commenced shelling the enemy, who are situated in a large kraal in a loop of the river, and fairly hemmed in on all sides by our troops with guns on every available position. Cronje refuses to give in, although we have destroyed the better part of his waggons, horses and cattle. We have shelled them night and day; our loss is not heavy, though we have several killed. Oh, the smell! Hundreds of horses and cattle floated down in the flood to-day; in one pool of the river I counted thirty-five dead horses. Yesterday I went along the banks of the river with my revolver and shot numerous wounded horses and cattle; poor brutes; you can hear them moaning like human beings; some standing on three legs, the other being blown off. The sights are awful. I wish the governor had sent me more hooks and some flies; the river teems with fish and I supply our little bivouac with many a meal. To-day I caught two, each were one pound. We are on *quarter* rations, and I wake up in the night with hunger. I am always hungry now, and at the present moment I could comfortably stow away four ordinary dinners. We are miles from anywhere; no mails! We are in the rainy season now, and I get wet to my skin most nights. We have no tents; I sleep under a waggon."

Appointments.

HOUSE APPOINTMENTS.

The following appointments have been made by the House Committee upon the recommendation of the Medical Committee:—

House-Physicians.—Messrs. J. G. Taylor (Dr. Hale White); A. E. Clarke (Dr. Perry).

Assistant House-Physicians.—Messrs. J. F. Northcott, W. G. Stewart.

House-Surgeons.—Messrs. H. A. Gaitskell (Mr. Howse); L. Wilkin (Mr. Golding-Bird); and F. W. Brook (Mr. Jacobson) (three months).

Assistant House-Surgeons.—Messrs. C. T. Hilton, F. Shufflebotham (Front Surgery); H. Durbridge (Mr. Symonds); A. H. Davies (Mr. Lane); A. G. Osborn (Mr. Dunn); O. Marriott (Mr. Fripp).

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants.—Messrs. E. W. Goble, G. Lewin, B. W. Moss, E. E. Parrett, H. McD. Parrott, C. B. Thomson.

Clinical Assistants in Medical Out-Patients.—Messrs. R. M. Barron (Dr. Shaw), W. M. Thomas (Dr. Washbourn), P. S. Mandy (Dr. Bryant), J. S. Steele-Perkins (Dr. Fawcett).

Obstetric Dressers.—Messrs. T. B. Fawley, T. E. Holmes (April 1st).

Dressers in the Throat Department.—Messrs. W. B. Secretan, F. D. Turner, F. G. Cross, K. V. Trubshaw, F. G. Gibson, T. P. Thomas.

Clerks in the Throat Department.—Messrs. C. H. Gask, J. A. Andrews.

Assistant Surgeons' Dressers.—Messrs. F. C. Wetherell. W. J. Davies, J. A. Andrews, S. Child, E. G. Allport (Mr. Symonds); E. J. Crew, E. Bigg, H. J. Gater, H. P. Wiltshire, H. D. Kempthorne (Mr. Lane); G. Evans, D. H. Trail, M. A. Collins, A. C. H. Gray, C. Tessier (Mr. Dunn); F. D. S. Jackson, H. W. Brown, S. S. H. Shannon, R. C. Lawry, G. H. Manfield, V. M. Wallis (Mr. Steward).

Medical Ward Clerks.—Messrs. D. S. Graves, B. Churchill, J. C. Curtis, W. H. Bowen, M. Coplans, F. Richmond, A. H. E. Wall, M. W. Cohen, H. A. Cutler, J. W. Gromitt, G. F. Humphrey, W. G. Parker, H. Barber, J. C. O. Bradbury, C. E. Bartlett, R. H. Terry, F. M. V. Smith, G. B. S. Soper, F. L. Thomas, A. J. Beadel, N. N. A. Houghton, W. W. C. Jones, W. C. Lewis, A. E. H. Pakes, G. E. Malcolmson, P. N. Blake Odgers, F. H. Parker, A. J. Urquhart.

Assistant Physicians' Clerks.—Messrs. W. A. G. Stevens, T. G. Miles (Dr. Shaw); C. H. Gask, A. H. Turner (Dr. Washbourn); G. Moir (Dr. Bryant); R. T. Collins (Dr. Fawcett).

Surgical Ward Clerks.—Messrs. L. Gifford Nash, F. J. Turner, C. H. Bubb, W. H. Cole, A. W. Iredell, J. D. Pearson, M. C. Wetherell, C. J. Pinching.

Clerk in the Skin Department.—Mr. J. S. Steele Perkins.

Dental Surgeons' Dressers.—Messrs. R. C. Mullins (April–May); A. C. Lewis (May–June).

Aural Surgeon's Dressers.—Messrs. T. J. Wright, J. A. Butler, H. S. A. Alder (May–June).

Post-mortem Clerks.—Messrs. F. A. Beattie, T. A. Matthews, R. S. Roper (April–May); J. M. Brydone, P. W. L. Camps, T. H. B. Dobson (May–June).

Assistant Demonstrators of Histology (Summer Session, 1900).—Messrs. P. R. Bolus, W. F. Box, P. A. Peall, A. M. Webber.

DENTAL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Dental Council:—

Assistant House-Surgeons (April–June).—Messrs. E. W. Corfe, T. Walkington.

Demonstrators in the Conservation Room (April–September).—Messrs. G. W. Badcock, A. H. Clogg, S. W. Iles.

Assistant Demonstrator of Dental Microscopy (Summer Session).—Mr. E. J. Gaffney.

Nursing News.

Matron's Office.

The Nurses' examination in Materia Medica and Pharmacy took place on Monday, the 26th inst. The result will be given later.

On the 29th inst., the Probationers' Medical Lectures commenced, and the Sisters' classes will begin the following week.

On the 19th inst. Nurse Roffey left the Hospital at the end of her three years' training, and Nurse Reed (Theatre Nurse) was transferred to Stephen ward; Nurse Custance, Head Nurse in Job ward, was transferred to the Theatre, and Probationer Swadling was appointed Head Nurse in her place.

Nurse Frankham, Head Nurse in Philip, leaves on the 31st inst., on completion of her three years' training, to take up maternity work previous to going abroad for missionary work. Nurse Studdert has been appointed Head Nurse in Philip ward in her place.

Nurse Bowen, Head Nurse in Naaman ward, also leaves on the 31st inst., having completed her three years' training, and Probationer Houstoun has been appointed Head Nurse in her place.

Sport.

Rugby Football.

GUY'S v. LONDON IRISH.

(Drawn. No Score).

An enjoyable, if rather unconventional, game was played at Herne Hill on Saturday, March 17th (St. Patrick's Day), when a scratch team from the hospital met the London Irish. As it was not desirable to disorganise the Second Fifteen, in view of their engagement in the Surrey Cup competition, the fifteen had to fall back on some veteran players to complete their number. This, together with the fact that the match was played under the direct auspices of the Irish Patron Saint, caused the game to be of a somewhat erratic description, though it was always keenly contested with the utmost good humour on both sides. Mullins won the toss, and the Irish started the game. O'Brien returned well, and a series of scrambling scrimmages took place in the centre of the ground, Guy's usually securing the ball, though neither side could claim much advantage. Opening the game up well, our three-quarters got in some good bouts of passing, and Manson, who was playing on the wing, looked like scoring. McEvedy also, at centre, did some smart dodgy work, and was only tackled on the home goal-line. After a tight scrimmage the ball was run over, and the Irish touched down. Dyers and Bulger were both playing hard, and worked down into our quarters, but Hilton tackled well, and our lines were soon cleared. Some good work was done by our forwards, who screwed the scrums well, and followed with good loose rushes, in which Featherstone was especially prominent. Half-time arrived with no score, but the game so far, rather in favour of the Hospital.

On resuming, Wall played three-quarter in place of Manson, and Guy's went off with a good rush to the Irish twenty-five, but Dyers got well away, and being missed by most of our backs, was only tackled on the line, and had bad luck in losing the ball as he fell. For some time the Irish, who were now playing with vigour worthy of a cup-tie, attacked, and Guy's touched down. Pye-Smith, O'Brien and McEvedy got in a good rush and attacked, but Hilton handed on. Bulger then got through our backs, but had not enough pace, and was taken by Harrison; the home side continued to have slightly the best of matters until the end of the game, when honours were easy, and we sprinkled the shamrock together. Team:—

Guy's.—E. M. Harrison (back); C. T. Hilton, A. O'Brien, J. McEvedy, C. D. Pye-Smith (three-quarter backs); R. C. Mullins, D. H. Trail (half-backs); T. P. Thomas, A. H. Wall, P. T. Manson, E. G. Goddard, G. Shorland, F. R. Featherstone, H. Pinching and F. G. Gibson (forwards).

GUY'S 2ND XV. v. SUTTON.

(SUTTON, 18 POINTS; GUY'S, 7 POINTS).

This, the Semi-final Tie in the competition for the Surrey County Cup, was played off at Honor Oak Park on the 17th instant, in the presence of an assemblage consisting largely of Sutton supporters, who, at the outset expected a handsome win for their side, expectations, alas, too fully realised. Sutton winning the toss, guarded the Pavilion goal, and shortly after 3.15, Guy's kicked-off, as the result of which play at first settled down in the Sutton twenty-five. A determined rush by the Sutton forwards, from an indifferent throw-out by their half-back, carried the game well into the Guy's quarters; keeping up the pressure, Sutton soon worked the ball down to our line, when, from a scrimmage well held by our opponents, their outsides gained possession, and after some poor passing, a try was obtained for them far out, five minutes from the start; the kick at goal, though a good one, failed. Encouraged by this early success, the Sutton fifteen played a vigorous game, and were soon pressing after the drop-out. An ugly rush by their forwards was saved grandly by Hicks. In the loose our forwards, who constantly showed up well in this direction, by the help of Brown and Kynaston, dribbled the ball over the Sutton line, but their full-back was just able to touch down. After twenty minutes' up and down play, in which for the most part Sutton were the aggressors, a somewhat lucky try was obtained by Anderson for Guy's; the kick by Milson failed, and the score stood 3 points all. The play from this moment was all in favour of Sutton, who repeatedly pressed, and for the most part play settled in the Guy's twenty-five. Our defence was sorely tried, but owing to the indifferent passing of the visiting outsides, the Guy's fifteen were spared further scoring for some time. Bridger, at back, did good work for his side, his tackling and kicking being particulary clever at times. From a line-out, the Sutton outsides combined very prettily, although the Guy's line of defence was lamentably weak, and another try was added to the visitors' score. On resuming, some off-side tactics on the part of Sutton relieved the pressure on the home side, and the Guy's forwards, amongst whom Thompson, Anderson and Collins figured prominently, carried the ball well into the visiting twenty-five, whence, after some loose and wild play, Thompson dribbled over the line; the try, however, was not allowed. Shortly before half-time, Sutton scored again.

The play in the second half was, if possible, yet more uninteresting and one-sided than in the first, and Sutton proved themselves again and again the better team. The passing amongst their outsides was slovenly, however, else had the score been greater against us. From a mark near the twenty-five line, Sutton kicked a good goal, which made Guy's wake up a little more, and determined efforts were made to score on more than one occasion towards the end of the second half, but the Sutton forwards always held the upper hand in the scrum, and were vastly superior behind the pack, both in the matter of attack and defence, though it must be admitted that in the former respect the Guy's outsides had few opportunities given them. Individually our fifteen showed a measure of science, but collectively lacked combination and cohesion. The defence of our outsides was weak, and seldom was marking done at all. Before the final whistle blew, Guy's scored again through the instrumentality of Louisson, but the end came with the complete victory of the Sutton fifteen by 2 goals and 3 tries to 1 goal and 1 try.

The Pavy Gymnasium.

SUDDENLY conceived, hurriedly organized, there was every excuse if the Assault-at-Arms in the Gymnasium on the 16th inst. had been a failure. When, therefore, we can describe it as a complete success, there is every reason to congratulate the prime movers in the entertainment on the result of their labours. The programme comprised boxing, gymnastic and fencing competitions, and last, but not least, an exposition of "Bartitsu" under the direction of Mr. Barton Wright, and a display of Elizabethan sword play by pupils of Captain Hutton.

The preliminary rounds in the boxing competition had been decided on the previous evening, and only the final tie was included in the programme, and the committee very wisely arranged that this event should be fought out at the beginning of the evening somewhat before the advertised time of commencement. Soon after eight o'clock Dr. Pavy took the chair at the judges' table, and his arrival was the signal for a hearty demonstration by the audience in appreciation of the lively interest which Dr. Pavy takes in everything connected with the hospital.

A persistent rumour had been abroad that Dr. Taylor and Dr. Savage were to give an exhibition of modern foiling, and the arrival of Dr. and Mrs Taylor certainly seemed to lend colour to this view. But rumour lied, and we were not permitted to see what would undoubtedly have been the most popular item of the display. Of the boxing we can do no more than quote the familiar sporting phrase that "both were likely lads and fought to win." Perhaps it was significant that at the prize distribution afterwards the winner appeared with both wrists in strapping, while the loser did not appear at all! The gymnastic display was not good. With one or two notable exceptions the men did not show anything like the form that is expected at these occasions, and the set pieces showed a lack of rehearsal which was no doubt due to the paucity of time at the disposal of the instructor. One item, however, gained rather than lost by this rawness; it was intensely funny to see and hear the surprise and indignation of one of the pair of men who should have "circled" head to foot, when his partner attempted to go round the wrong way.

The fencers gave a much better show, although the hits were rather soft and generally of the "lay on" type. Then M. Vigney and Mr. Collard, two of Mr. Barton Wright's instructors, gave an exhibition of "Bartitsu" walking-stick play. Everybody has heard of this new

defence and offence, but it was a revelation to the audience to see the splendid development, the dexterity and quickness, and even grace, of the exponents of this really wonderful science. A striking feature of the training is that in all the exercises the pupil must become ambidextrous; in fact, the rapid transference of the walking-stick from one hand to the other was, to the uninitiated at least, one of the most powerful factors in offence and defence, and one likely to prove most puzzling to the opponent. After another round in the fencing competition, Captain Hutton brought forward two of the "Bartitsu" Club fencing instructors, Messrs. Collard and Rolt, who gave a display of Elizabethan fencing, using first of all sword and buckler, and then, the more stately rapier and dagger.

The two styles were essentially different in all but attitude. Neither man came "on guard" with the stilted style of modern foil play. Crouching at either end of the ring, they crept towards one another like tigers, and sprang in and out, thrusting and guarding with lightning rapidity. From a spectacular point of view these contests were superb; but it was unpleasantly obvious that "an affair of honour" in Raleigh's time was not a matter to be entered upon lightly, and certainly not a matter from which either party could hope to escape unscathed. With these events the programme ended, and after a short speech of thanks from the Chairman to Captain Hutton and Mr. Barton Wright, and the gentlemen who had judged and given displays that evening, Mr. Cross proposed a vote of thanks to Dr. Pavy for taking the Chair, and for presenting and giving the prizes. With cheers for Dr. Pavy and Captain Hutton, the proceedings terminated. Programme:—

FINAL TIE OF BOXING COMPETITION.—Mr. Pern beat Mr. Palmer. Referee: Mr. Godtschalk (*Mirror of Life*). Timekeeper: Mr. Griffin.

GYMNASTIC DISPLAY. — Winners Squad B (Messrs. Robinson, Steele-Perkins and Beattie). Judges: Mr. L. A. Dunn and Colour-Sergeant Young.

FENCING (Final Heat).—Mr. Jensen beat Mr. Roper. Referee: Captain Hutton. Judges: Mr. Clay and Mr. Norbury.

"BARTITSU" DISPLAY.—Messrs. Vigny and Collard. Judge: Mr. Barton Wright.

SWORD PLAY.—Sword and Buckler, Rapier and Dagger.—Messrs. Collard and Rolt. Judge: Captain Hutton.

S.

Guy's Hospital Chess Club.

INTER-HOSPITAL CHESS SHIELD.

We are very glad to find ourselves within measurable distance of securing this trophy for the adornment of our Smoking-room. Of the six other clubs who entered the competition, three (Middlesex, Bart.'s and Mary's) scratched through their inability to raise a team of six. University also scratched, because of a disagreement as to date on which our match should be played. The other two clubs, George's and London, we were able to draw with. We are thus two points down—counting two for a win and one for a drawn game. The dispute with University is to be settled at the Inter-Hospital Chess Meeting on Thursday the 29th. We hope this will be in our favour, if so we win the shield, if not we play it out.

The following are the results of matches with St. George's and London:—

GUY'S v. ST. GEORGE'S.

Played on March 14th.

1. Dismorr	½	Christian	½
2. Stewart	½	Dr. Grünbaum	½
3. Kennard	1	Bond	0
4. Kitchin	½	Jones	½
5. Russell	½	Powell	½
6. Robinson	0	Manuel	1
Total	3	Total	3

GUY'S v. LONDON.

Played on March 23rd.

1. Dismorr	0	Turnbull	1
2. Stewart	0	Culpin	1
3. Kitchin	0	Beet	1
4. Kinnard	1	Stanham	0
5. Russell	1	Moscroft	0
6. Robinson	1	Marsh	0
Total	3	Total	3

I hear that there are several men anxious to join the Club. If those men will let me have their names, I shall be better able to find them.

EDGAR FAULKS, Hon. Sec. Chess Club.

Papers by Guy's Men.

Foreign Bodies and the Roentgen Rays.—*The Physician and Surgeon*, No. 4.

Fractures and their Investigation by the Roentgen Rays.—*Ibid*, No. 5.

Diseases of the Bone and the Roentgen Rays.—*Ibid*, No. 6.

The Elbow-joint and the Roentgen Rays.—*Ibid*, No. 7.

Births.

GOODALL—On March 5th, at Homerton, the wife of E. W. Goodall, M.D. Lond., of a daughter.

HANCOCK—On March 14th, at Grove House, Belsize Grove, Hampstead, the wife of William Albert Hancock, F.R.C.S., of a daughter.

LANSDOWN—On March 21st, at 39, Oakfield Road, Clifton Bristol, the wife of Robert G. Poole Lansdown, M.D., of a daughter.

LUCE—On March 15th, at Friargate, Derby, the wife of R. H. Luce, M.B., F.R.C.S., of a son.

TYSON—On March 15th, at Folkestone, the wife of W. J. Tyson, M.D., of a daughter.

TYSON—On March 23rd, at The Beeches, Lowestoft, the wife of Wilson Tyson, M.A., M.B., B.C. Cantab., of a daughter.

ED.—S. H.

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Calendar of Coming Events.

April, 1900.

Sat. 14.—Messrs. Lucas and Lane's take-in; Drs., N. F. Ticehurst and F. W. Sime; Cl., G. Lewin.

Sun. 15.—Easter Day. Service in Chapel at 11 a.m.

Mon. 16.—Easter Monday. Medical Office closed.

Wed. 18.—Last day for sending in Fees and Certificates for Third M.B. Camb.

Thur. 19.—Messrs. Golding-Bird and Dunn's take-in; Drs., P. T. Manson and M. D. Wood; Cl., E. E. Parrett.

Mon. 23.—Third and Final M.B. Durham Exam. begins.

Tues. 24.—Cambridge Third M.B. Exam. begins.

Thur. 26.—Messrs. Jacobson and Fripp's take-in; Drs., F. Curtis and L. E. Stamm; Cl., E. W. Goble.

Guy's Hospital Gazette,

APRIL 14, 1900.

Torticollis, or Wryneck.

CLINICAL LECTURE BY MR. GOLDING-BIRD.

March 14th, 1900.

GENTLEMEN,—We have at this moment in the wards a child suffering from a deformity of the neck, whereby his head is turned constantly towards one shoulder, and if anyone unfamiliar with the condition were to examine him, he might take a very different view of the case, according to the way in which he looked at him. Examined from the front, the child seems to have something wrong with the right side of his face and the right sterno-mastoid muscle, whilst from the back he would appear to have lateral curvature of the cervical spine, the concavity being towards the right hand.

To give this curious deformity a name at once, without for the moment defining the variety of it, I may say it is a case of Torticollis, or Wryneck; and whilst the report, carefully drawn up by my clerk, Mr. F. L. Thomas, is as full as I could expect, yet it is no disparagement of his clerical powers to add that it is not full enough. He has observed just the salient points that strike the eye, but when you and he become more deeply acquainted with the variety of wryneck which this case illustrates, you will agree that there is much more to be said about it.

The public, you know, think little of wryneck; in fact, it has generally to be pointed out to them, and when they see it they regard it is as "only" a wryneck, like they might say of another case, "it's only a cold." When you have learnt all the little details and point them out one by one, it is surprising how the parents of children, without exception, blame themselves—and I think, rightly—for not having noticed the condition before.

The case is that of Cecil R., æt. 8, who says he always has had his neck deformed as it is at present, and he thinks it is, as he grows, getting worse. It causes him no pain.

The child is in perfect health and the head and neck exhibit the deformity characteristic of congenital wryneck (*vide* later). There is also marked lateral curvature of the cervical spine with the concavity to the right, and from the head being drawn down towards the right shoulder, as well as advanced, there is a horizontal crease well marked in the right front and side of the neck.

(The above notes are from the report of Mr. F. L. Thomas. The description of the condition comes out in the course of the lecture.)

Now, by wryneck you might mean any form of turn or twist of the neck, and in general it means that, just as "whitlow" may mean more than one form of inflammation of the finger, but to treat the latter you must carefully distinguish the variety before you, and it is just the same with the former.

There is one form of wryneck that we may at once eliminate, that known as a false wryneck, for it does not depend upon any muscular contraction or rigidity or spasm, but on the contraction of the fibrous tissue resulting from any large loss of skin of the neck, as, for instance, after severe burns. As you will see, when I have the child before you, he has suffered from no neck injury.

The other forms of wryneck that at the bedside would occur to you as offering an

explanation of the child's deformity at first sight, would depend on some inflammatory condition of the tissues of the neck, that by spasm, or actual swelling, or pain, forced him to hold his head on one side. A careful account of the history of the case—though this, perhaps, is the least valuable of all the methods of arriving at the truth—would help you; and then a local examination should reveal whether there were, for instance, commencing cervical caries. This may force a child's head, round either by creating spasm of the muscles, or by the very mass of inflammatory thickening around the spine deeply in the back of the neck; whilst in that rare condition, atlo-axoid disease, the head may be sent over to one side, though slightly, by reason of one atlo-axoid joint being diseased and thus allowing the head with the atlas to become advanced on the affected side; for unlike the first form of cervical disease already referred to, it is one starting in the synovial membrane of the joint followed by undue mobility of the same.

On examining a child of the class seen at hospital out-patients, it is well to bear in mind that at times the little patient may present a head held more or less on one side, and a distinctly painful inflammatory condition of the nuchal area, without there being any spinal disease at all; the fact being that he has acute deep lymph-adenitis from the irritation produced in the scalp by the presence of certain unnecessary organisms belonging distinctly to the animal kingdom.

There is yet one other form of wryneck to which I must refer, though it is not an affection of children but rather of their parents; it is known as the rheumatic form, and results from draughts, generally in travelling, playing unduly upon the neck of a person insufficiently protected by clothing. The city man, tired out, falls asleep in the railway carriage against the open window, and though he may not feel much of it before bedtime, is likely to awake in the morning with a stiff or "wry" neck, the sterno-mastoid, splenius, and upper fibres of the trapezius being the most usually affected muscles. Spasmodic (clonic) wryneck I only mention to pass over. The true deformity which is characteristic of wryneck is best studied in such a case as the one before us to-day, namely, the congenital variety (so-called) in which the position taken up is purely the outcome of a stiff and shortened sterno-mastoid, and though other structures become eventually involved, this does not change the characteristic posture in which the head is carried.

We will now examine the child. You see him to be a healthy, happy-looking little chap, with nothing of the invalid about him, and as he stands before you with a thick muffler round his neck, I fancy that many of you will detect nothing wrong about him. But observe now his face, and note the disparity in growth, plumpness, and actual size of its halves, the right half is clearly the smaller. The distance between the lower margin of the right orbit and the mouth is less than on the left side, and the eye therefore has the appearance of being carried at a lower level than that on the left side, and so it is; but I am bound to confess that part of this unevenness is due to the fact that the head is inclined to the right shoulder, as you shall see directly. The right ear in this case is not appreciably smaller than the left in the vertical measurement, there being barely an eighth of an inch difference. Whilst, therefore, to the eye the facial disparity is distinct, it is not, in this particular case, so marked as in some others. I have measured, in a child of seven, with congenital wryneck of the right side, full half an inch shortening of the cheek on the right side, between the orbit and angle of the mouth.

I now hand you round several photographs of children with congenital wryneck that have passed through my hands, and you will not have the slightest difficulty in recognizing the facial arrest of growth on the affected side. And here I may remark that there are two ways of intensifying this disparity, so that the most infatuated parents who will not believe there can be anything wrong with their child's face are at once convinced. The one is to ask for the family album, and as surely as you can pick out the photograph of your small patient, so surely will the facial deformity be apparent; much more so than in the subject of it himself very often.

The other is to make the patient look at himself in a mirror, whilst you watch the reflection over his shoulder; the want of symmetry is at once startlingly visible. Perhaps it will astonish some of you to learn that there are few faces that can stand this test; it is remarkable how many of one's friends, with whose faces one is quite familiar, show when studied in a mirror, a marked asymmetry, intensified if the subject of it smiles. In a word few noses are in the exact middle of the faces to which they belong!

On now exposing this patient's neck you will at once observe that the head is inclined to the right shoulder, that the face is looking round

toward the left side, the right eye being on a lower level than the left; in fact I cannot compare the position to anything more fitly than to that taken up by the barn-door fowl when with head on one side he is watching on the ground something which he is doubtful of as a suitable article of diet!

On now trying to put the head straight you at once observe a rigid cord extending from clavicle to mastoid, in the line of the right sterno-mastoid; and all endeavours, even under an anæsthetic, will fail to relax this cord-like structure, which is in fact a shortened and altered sterno-mastoid muscle.

It is not in a condition of muscular contraction; it is only "contracted" in the sense that unopposed fibrous tissue will contract; and it is actually shorter than its fellow. You at once now understand from your knowledge of the action of a normal sterno-mastoid muscle, why the face, in congenital wryneck, is posed as I have described it just now. Not only, too, is the head pulled down, but the clavicle is markedly raised at its sternal end. On feeling on either side of this rigid band the tissues of the neck seem less supple than usual; the cause of this is seen in operating (by the open method) in these cases to be due to shortening and consequently tightness of the platysma and deep cervical fascia. On passing the hand down the child's cervical spine, behind, the curvature, to which I have already referred, which is the consequence of the pulling down of the head to one side, is easily felt; but I may dismiss further reference to it by saying that it is of no importance, since if the sterno-mastoid is divided and the head replaced in its normal position the curve in the spine presently disappears.

As this remark is of the nature of a prognosis, I may as well add here that operation, whilst replacing the head, does not always cause the facial asymmetry to disappear. Some writers say positively that it does; at least I can show you the photograph of a young lady, æt. 15, on whom I operated six years before; and if you compare it with the photograph before operation, you will admit that in her case the facial asymmetry still remains.

You will now ask why we call this case before us "congenital"; it is true the mother said it had existed from birth, but it is not the usual history given; more often a child of seven or ten years old is brought to the surgeon with the story that the deformity has only just appeared; and when I remind you that a rigid fibrous sterno-mastoid (generally on the right side), accompanied by facial hemiatrophy of the same side, are the diagnostic characters of the "congenital" variety of wryneck, it is clear that a short history will not suit these facts.

I wish I could at once tell you for certain the cause of the affection of the sterno-mastoid: but it is not known. It is generally attributed to injury at birth, and is believed to be associated with the firm gummatous-like deposit seen at times in the sterno-mastoid of the newly-born, and regarded as primarily a hæmatoma, which subsequently—unless it disappears, as it often does—is converted into a firm fibrous lump. I believe Dr. Frederick Taylor was the first to have the opportunity of examining one of these swellings microscopically; he described it in vol. xxvi. of the Pathological Society's Reports.

I cannot—since it has no bearing on treatment—discuss with you here the pros and cons of the connection of this rigidity of the sterno-mastoid with the deposits in infancy, but I may tell you that in all the cases of congenital wryneck I have seen I have been unable to learn of any lump in the muscle or injury to it during birth; whilst in a published analysis of eighteen cases of "lump" in the sterno-mastoid in infants only two were known to be followed by wryneck. Besides, in the mere want of growth of the muscle, how is the arrested growth of the face to be explained? Some twelve years ago I ventured on an explanation—purely hypothetical, I admit—which had for its basis the same pathology as that that belongs to a club-foot from infantile paralysis, where the affected foot is also undersized; but I must refer you to a back volume of the Guy's Hospital Reports for anything further about it, and indeed in a clinical lecture further reference to pathology would be out of place.

The treatment of these cases of congenital wryneck is most satisfactory, at least as far as the reposition of the head and the obliteration of the cervical spinal curve are concerned. As I have already mentioned, I am doubtful of any great improvement in the size of the smaller side of the head.

Mechanical treatment, without the previous division of the sterno-mastoid muscle is useless, the altered muscle will not yield to any stretching force that can be reasonably applied to it. There are two methods by which the muscle may be divided—(i.) subcutaneous, (ii.) by open operation.

(i.) Subcutaneous method. The division of the muscle is carried out just above its sternal and clavicular origin, the tenotome being entered at the inner margin and made to cut either outwards or inwards according to the

fancy of the surgeon. I need hardly point out that there is considerable risk of wounding one of the many veins in the neighbourhood, and that the introduction of a grooved director behind the muscle, after a preliminary puncture through the underlying structures along which the tenotomy knife is then passed, safeguards the operator to some extent but not entirely. I well recollect performing this operation many years ago some little distance from home. In spite of every care the knife opened a vein, and on its withdrawal blood poured out through the puncture, whilst a finger placed upon it to arrest the bleeding only caused a hæmatoma the size of a small orange at once to appear. As, however, the bleeding was clearly venous, the appropriate treatment was easily adopted, viz., to put a stout pad over the whole area that had been subcutaneously traversed by the knife, and firmly bandage it on. This I did, and no further trouble ensued; the child made a perfect recovery.

Such a contretemps, however, no operator cares even to risk if it can be avoided, and in these days there is not the same call for subcutaneous surgery as formerly, the same fear of inflammation not any longer restraining the surgeon from employing a free incision.

The subcutaneous method has the advantage of leaving no scar to speak of, but it certainly possesses two very serious drawbacks beside that of the risk of venous hæmorrhage of which I have just spoken.

One of these is, that the operation must be necessarily incomplete, for when the open method is adopted it is seen that when the sterno-mastoid has been divided, the platysma and the various layers of deep cervical fascia are still holding the head down, and not until these are divided will the head be entirely free. I have divided the deep fascial layers behind the sterno-mastoid so thoroughly as to expose the deep vessels just above the sterno-clavicular joint. Such extensive division of preternaturally shortened structures cannot with safety be even attempted by the subcutaneous method.

The other drawback is that because of the incomplete division of all the tissues concerned, a prolonged after-treatment becomes necessary in order to stretch them, and thus the child is not out of hand for many weeks. The principle adopted for such after-treatment consists in providing the child with a closely-fitting coronal band of some sort, or a scull cap, to the back of which is fastened an indiarubber spring of suitable strength, this in its turn being fastened to a stiff jacket or corset in such a way that when the spring is acting the face is made to look in exactly the opposite direction to that in which it had always been carried, and this apparatus must be worn constantly for some weeks.

(ii.) *By open operation.*—In performing this operation a horizonal incision is made across the sterno-mastoid half an inch above its origin, or a flap may be employed, though this is not necessary. Step by step it is now easy to divide the sterno-mastoid horizontally, and then all fascial bands beside or beneath it that prevent the restitution of the head. In most cases some fibres of the platysma are divided also; and in one of my cases, satisfactorily to do this I had to extend the incision posteriorly rather beyond the limits of the sterno-mastoid, in order very thoroughly to divide the part lying over the subclavian triangle.

So complete can be the freeing of all restraining tissues that the head is at once able to be brought round to the normal position by this method; or to be strictly correct, I should say that it is only now hindered by whatever may remain of curvature in the cervical spine; this, however, disappears in a short time. Since the skin has to be united after the operation, and is itself a factor in keeping the head in its false position, it is not wise to forcibly restore the natural pose of the head until the skin wound has united, or it may gape. Superficial healing having taken place, the after-treatment, which is simplicity itself, can be commenced. It consists merely in the mother or nurse manipulating the head round frequently during the day, or in the case of children over, say seven years, they can be made to use one of the various forms of calisthenic exercises employed in spinal curvature, in which the child can draw itself up and down on a rope by the hands, there being attached to the rope also a head support or band, so that the head is drawn up at the same time—in fact, the child swings from hands and head. Thus, a maximum of extension on the direct line of the spinal axis is obtained. The simplest method of doing this is to have a length of rope passing over a single pulley fixed overhead; one end of the rope carries a "head band" of any of the recognised forms, through the medium of a small crossbar, whilst the other end of the rope is held in the child's hands, and he is taught to "climb up" it hand over hand, thus literally pulling himself up by his own head. No risk attaches to this if the hands are always kept at their highest stretch above the head level.

Such an exercise, if used at all, can be used for a month, and then discarded.

I know of but two drawbacks to this open operation — one, the introduction of a scar, which in the case of a girl might be detrimental, but considering that many years must elapse before the scar would become a matter of moment, it will have had plenty of time to practically, though I admit not entirely, obliterate itself.

The other objection is the risk, in some children, of scars becoming keloid, and then, though the tendency of such keloids is to disappear, they may take years to do so, and are never likely to do so as completely as a scar that has never hypertrophied. I had this very forcibly brought home to me three or four years ago.

In a schoolboy, who was just beginning special training with the view to joining one of the services, I had to divide the sterno-mastoid for congenital wryneck. I chose the open method, and, indeed, from what I then had to divide it is clear to me that subcutaneous division must have been very incomplete. I closed the wound and healed it with a small collodion dressing. Everything followed an asceptic course, but the collodion blistered the skin; a keloid mass a quarter of an inch thick, and of the exact size of my dressing, formed in a few weeks, and when some months later the lad had to present himself for his first medical examination, he was promptly rejected, and the whole course of his future life had to be changed.

I need hardly add that keloid formation has no connection with the operation as being one on the sterno-mastoid, but it certainly is more seen about the neck and shoulders than elsewhere; and hence there is always in children just the risk of its appearance. This will not, however, deter me from following the open method when I operate to-morrow upon the child I have shown you to-day. The steps of the operation will be those I have indicated. The after-treatment, when he leaves the hospital, considering his station in life, is likely to be nil, as I doubt if his mother will trouble to restore the head to its normal position, and thus get him out of the habit of holding it crookedly. Still, for all that, I am sure that if we could see him in a couple of months' time, he will be, as far as head position is concerned, quite cured.

Note.—The open operation was afterwards performed on the lines suggested in the lecture, and all restraining parts besides the muscle freely divided. Being anxious to give the child the full benefit of skilled attention before he left the hospital, reposition of the head by manipulation was begun before the skin had firmly healed. It gaped, therefore, for about a quarter of an inch at one extremity of the scar; otherwise the wound healed primarily and aseptically.

Pass List.

Second Conjoint Examination, April, 1900.

K. Black, S. C. Bowle, W. F. Box, G. Carlisle, C. H. Dawe, W. L. M. Day, E. J. Gaffney, H. M. Goldstein, R. Larkin, E. H. B. Milsom, P. A. Peall, C. D. Pye-Smith, G. S. Robertson, N. I. Spriggs, H. W. Wallis, A. M. Webber, B. H. Wedd, H. C. Winckworth.

First Conjoint Examination, April, 1900.

Part I.

Chemistry and Physics.—A. R. Beaumont, H. P. Costobadie, C. J. S. Dismorr, C. P. Harvey, H. H. Jenkins, A. V. Maybury, P. F. Minett, L. J. Patterson-Clavier, C. W. R. Preston, G. C. F. Robinson.

Part II.

Practical Pharmacy.—W. H. Cole, H. J. Gater, F. G. Goble, G. Moir, L. G. Nash, T. H. F. Roberts.

Part III.

Elementary Biology.—A. M. Benett, G. H. Cheyney, A. C. Dickson, C. J. S. Dismorr, T. H. Edey, I. R. Fearn, R. D. Hirsch, H. H. Jenkins, P. F. Minett, M. J. Mottram, L. Myer, J. E. Prentis, W. Reeve, R. M. Rendall, A. Shepperd, G. H. Sherris, H. D. Wyatt.

Royal College of Surgeons of England, April, 1900.

PRELIMINARY SCIENCE EXAMINATION (L.D.S. Eng.).

F. R. E. Palmer, H. L. Whitlow, C. D. Wood.

Royal Army Medical Corps.

The Medical Council are authorised to nominate a candidate to fill one of the vacancies in the above corps, and will be pleased to consider applications from qualified Students of Guy's Hospital.

Applications should be addressed to the Dean, Medical School, Guy's Hospital, on or before mid-day Tuesday, April 17th.

"COMFORTS FUND."

The following is an addition to the list previously rendered:—

	£	s.	d.
Percy, F. Henry, Esq., L.D.S.	0	10	0

With the Army Medical Corps in South Africa.

(By Our Special Correspondent.)

CONVALESCENTS RETURNED FROM THE WAR.

(Published by permission of the Director-General of the Army Medical Service).

SS. Nile.

Your special correspondent, having been sent home in charge of sick and wounded, is now on his return to South Africa after an interval of ten days at home. It has been intimated to him that criticism of official arrangements, whether favourable or unfavourable, cannot be allowed; but even a plain description of a hospital-ship at work, and of the invalids returned from a war, may be of some interest.

The hospital-ship Avoca, belonging to the British India Steamship Company, displaces some 3,100 tons, and had been used by the Government as a transport for several months prior to the war. She was transformed into a hospital-ship at Durban within a fortnight, at a cost of something under £6,000, and was designed to carry some 200 cases in cots and bunks—mostly swinging cots—and 150 in hammocks. This may be contrasted with the first hospital-ships fitted out in this war, the Spartan and Trojan, which held under 120 cases each.

On the upper deck a small officers' ward (fitted to accommodate six patients) was cut out of the saloon, but it was used by only four officers, the other sick and wounded officers occupying ordinary cabins on the same deck. Another small ward of twelve cots (Ward F) occupied the stern of the ship, just over the screw, on the same deck. Otherwise all the patients were below.

On the main deck.—Two wards of respectively forty and thirty-five cots, Wards E and D, occupied the hinder part of the ship, with port-holes a few feet above the water, necessitating their closure whenever the ship was in anything of a swell, and with a roof largely open, except in stormy weather, when the hatches were battened down. In front of the funnel was another large ward, Ward C, and under it, on the orlop deck Ward B, of about the same size. These two were chiefly reserved for the more serious cases, as it would have been difficult for the one night-sister on duty to attend to serious cases at both ends of the ship at the same time. The remaining or convalescent ward, Ward A, was comparatively small, as, although it held 150 patients, it took only hammocks, and these, being stowed away during the day-time, did not require much space. This ward was separated from the bows of the ship by quarters occupied by the N.C.O.'s and men of the R.A.M.C.

The men slept and ate their meals below, the meal hours being 8, 1 and 4.30. They were obliged to be finally below at 8.30, and lights to be out at 9. Otherwise they could spend their time, unless kept in bed by order of the medical officer, on the promenade (the uppermost) or on the upper deck, or below, as they liked. Ventilation was carried out by means of canvas windsails 4ft. in diameter leading into the wards, with their mouths facing the wind above the level of the promenade deck. The air was kept in constant motion by electric fans; and, although through the tropics the heat was of course intense, it was cooler in the wards than on deck, and never in the least degree close. The wards were fitted with refrigerators, with lavatories and water flushed latrines, and with hand-lifts by which bed-ridden cases could be taken up on deck for a few hours at a time.

The cooking-galleys, wash-houses and latrines for common use, with a special wash-house for venereal cases, the mortuary and the operating theatre all consisted of wooden sheds erected on the upper deck, and so freely ventilated. Fortunately we encountered no very severe weather; otherwise these sheds might have been in danger.

The ship was long and narrow. We accordingly pitched but little, and the screw was seldom out of the water; but we rolled 30 degrees on encountering a rather heavy north-westerly swell near St. Vincent's, and were obliged to use fiddles on the tables, and have ports closed in the wards for six days. Very few officers or men, however, were ill to any marked degree; and, although walking on crutches in so heavy a roll was difficult for the cripples, it was interesting to see how very well they managed. One cripple, with a right leg useless from below the knee, would get about on his crutches as well as any of them even in the heaviest roll, waiting at the saloon door perhaps, for the side of the ship to roll up towards him, when he would hop over the foot-board on to his sound leg, pull his crutches after him, and turn sideways to the roll, looking down the length of the ship, before that side of the ship rolled down again.

The medical staff consisted of sergeants and orderlies of the R.A.M.C., civilian orderlies and compounders, and of four civilian surgeons, all under the Principal Medical Officer, Major Butterworth, R.A.M.C., who was in charge of the wounded troops on board, as well as of the medical and nursing staffs. The Nursing Staff consisted of six civilian nurses and one nursing superintendent of the Army Nursing Service. Of these six nurses, one—changing every few days—was on night duty; one a trained masseuse was detailed off for massage and electric treatment, and, incidentally, as theatre sister; and the remaining four were in charge of the four large wards, one apiece. The nursing-superintendent looked after the sick and wounded officers; and the convalescent ward, containing amongst others the venereal cases, looked after itself, with the help of an orderly. As most of the cases were practically convalescent, the nurses for the most part had an easy time, and the medical officers a still easier time; but if the nurses had all been fully trained masseuses, they could without a doubt have had their hands full.

The medical officers consisted of the ship's surgeon, Mr. H. Hart-Jackson, acting also as civilian surgeon; Mr. J. F. Dell, an old Guy's man and a veteran traveller; Dr. Matthews, a prominent senior Uitlander at Johannesburg; and Mr. Fremantle. They divided the cases about equally between them; and took it in turn to be on duty as orderly medical officer for night work, for inspection of the sanitary and culinary arrangements, and for visiting the wards at meal times to hear and enquire into complaints about the food.

In general health, it may be said, the men picked up to a most marked extent on their voyage of twenty-three days, despite a week's rolling and consequent nausea and discomfort. Such improvement was due to several causes—generous feeding, both in quality and kind, absolute rest, the moral effect of nearing home; and in some cases also the treatment received, both medical and physical. The men, too, in the first instance are in good health, usually first rate health, and they are all select men.

The following table analyses the cases with regard to their main causes of being invalided home:—

1.	*Surgical*—		
	Gun-shot wounds	83	
	Shell-wounds	13	
	Contusions	6	
	Venereal diseases	39	
	Other surgical affections ...	25	
			166
2.	*Medical.*		
	Dysentery	71	
	Rheumatism	44	
	Enteric fever	9	
	Heat stroke	7	
	Other medical affections ...	40	
			171
	Total on board ship ...		337

This list probably gives a fair idea of the invalidings at the height of a campaign. At an earlier stage there would be comparatively few medical cases; at a later the proportion of medical cases, especially those of enteric fever, would be considerably increased. The proportion of gun-shot to shell wound is interesting as indicating to some extent the comparative value of the Boer artillery and small arms. But this proportion, or rather disproportion, is exaggerated in this list, inasmuch as shell-wounds are usually the most ragged and the most extensive, and therefore the most fatal. Fewer cases of shell-wounds survive to be invalided home.

It is interesting to note that all but one of the thirteen officers invalided home were surgical cases, and that the only exception was a case of nervous exhaustion. This is probably due to two causes. Firstly, on account of greater care and general cleanliness, and use of filtered and bottled waters when possible, officers are less liable to infection. Secondly, officers convalescent from moderately severe illness are often useful at the base if not at the front; whereas private soldiers and non-commissioned officers in the same condition are often unfit even for garrison duty.

The above classification refers only to the main cause of the invaliding of each patient. But many patients returned as cases of gun-shot wound developed dysentery in hospital; cases invalided for dysentery had often had some slight wound previously and had returned to duty before being taken ill; several had multiple wounds; some had multiple diseases; and thus it comes about that the writer's note-book includes some 150 wounds and 80 cases of dysentery.

The wounds are classified as follows:—

A.	*Head and neck.*		
	1. Cranium	8	
	2. Face	3	
	3. Eye	5	
	4. Ear	1	
	5. Neck	4	
			21
B.	*Chest.*		
	1. Penetrating	11	
	2. Non-penetrating ...	3	
			14
C.	*Abdomen*		5
D.	*Extremities.*		
	1. Bones	37	
	2. Joints	9	
	3. Large blood-vessels ...	5	
	4. Large nerves	11	
	5. Uncomplicated	52	
			114
	Total		154

The great majority of these wounds were received at the battle of Colenso on December 15th, two and a half months before the present report was prepared. This afforded, therefore, an interesting study of the after-effects of wounds, such as is hardly to be obtained elsewhere, whether in England, when the officers, at least, are scattered and the larger number of men are fit for discharge from hospital, or in the South African hospitals, in which the patients are constantly being changed.

It must be borne in mind that cases invalided home in February were those "unlikely to be fit for duty within three months," and "duty" included the lighter work of garrisoning the towns and guarding the railway bridges. Nevertheless, it was felt that even in such duty men might be called on to join fatigue parties, to do some lifting and carrying, and to be exposed to rain, sun and cold. It was necessary, therefore, to send home many men who, having suffered from rheumatism or heatstroke, or slight wounds of the extremities, would otherwise be soon liable to become again unfitted for such duty. In short, it was not worth the country's while to retain them at considerable cost in South Africa in the doubtful possibility of their being of use in three months' time. The Avoca, therefore, carried a

large number of men perfectly fit for civil duties, but unfit for the rigors of a campaign. In fact, all but twelve men walked down the gangway at the Albert Docks, and of the remaining twelve, who were slung over on stretchers by a crane, most were convalescent cripples, and were landed in this way for convenience rather than necessity.

There were five deaths during the voyage, all, be it noted, within the first half of the way from Cape Town home. One was a case of heat exhaustion, nothing being found after death except the congestion of superficial cerebral vessels usually described. One was a case of enteric fever. There were cases of dysentery, dying as usual of sheer exhaustion, despite energetic treatment by hypodermic injections of strychnine and digitalis. Ipecacuanha, magnesium sulphate, bismuth and morphia were each thoroughly tried in turn in the earlier stages.

1. *Surgical.*

A. *Wounds of head and neck.*

1. Cranium (8).—As a rule it may be said that the only cases of perforated cranium that survive are those shot through the frontal or occipital lobes. The exception to this rule was on the Avoca, an officer hit at Colenso, in the middle line of the head, one and three-quarter inches behind the centre of the line from the occipital protuberance to the root of the nose. The bullet left the skull at the top of the forehead, one and a half inches to the right of the middle line, fracturing the bone from one aperture to the other, rupturing the longitudinal sinus, and carrying brain matter with it, according to the report of the surgeon at Maritzburg. The bullet evidently passed through the right internal capsule. This patient was only unconscious for half an hour. He was removed by train to Maritzburg, and when admitted there was semi-conscious, with paralysis of the left arm, paresis of the left leg, and dilatation of both pupils, which were fixed, the right being the larger. The bone was gouged away and the sinus plugged without delay. On board the boat, the only remaining sign of paralysis was a slight ankle-drop. With some support on either side the patient could walk down the deck; he read and ate well, and his memory and power of thought were good. He was merely physically and mentally weak, could not bear noise, and was easily kept awake, and these symptoms abated very markedly on the voyage.

The other cranial cases had left but few signs, the commonest of which was headache; and this was often markedly improved by simultaneous administration of iodides and bromides. Two were left deaf in the left ear, one by direct injury, the other by an injury—probably external only—to the back of the head. One with a gutter fracture at the apex of the occipital bone, resulting in a definite loss of bone after operation, and another with a big trephine-wound in the occipital region, were perfectly well and active. One man hit in the forehead, the bullet leaving at the apex of the occiput, had recovered with a tender head and total blindness of the left eye. In this case, however, there was no opthalmoplegia, and the disc could be plainly seen, appearing to grow paler under observation. This, added to the fact that some bone was discharged from the nose nine days' after, and that there was at no time any paralysis, point to the conclusion that the bullet perforated the skull and the frontal lobe, but left the skull without touching the motor area of the cortex, and completed its course under the scalp. Lastly, mention must be made of a man hit on the occiput, without sign of bone injury, who was unconscious for two days, and completely blind except to light for another day, but recovered his sight in a fortnight, and is now only troubled by slight headache.

2. Face (3). Nothing of importance except contracting scars causing disfigurement, especially of the eye-lids, for which minor operations must be done.

3. Eye (5). Three of these had suffered from hæmorrhage into the posterior chamber, and had partial blindness, although no opthalmoplegia, external or internal. One had till recently some perception of light. A second, wounded at Lombards Kop four months previously, had some vision in the dark, but remained absolutely in statu quo, and the third was slowly clearing up and can now read, although when he looks down his sight is suddenly shut off.

4. Ear (1). A single case of deafness from an external wound which left also trigeminal neuralgia and headache. Examination was unfortunately prevented by the absence of speculum.

5. Neck (4). All of anatomical interest, but leaving few symptoms behind. One passed in at the middle line on the level of the third vertebra, and passed out just below the left malar bone. There was no pain or pyrexia; but the jaw was fixed, the antrum visibly distended, and an abscess was opened below the left angle of the jaw. Another case was shot by a bullet entering by the thyroid cartilage and lodged in one of the cervical vertebræ. There was now only occasional shooting pain to the shoulders, and limitation of movement to 10 degrees in a horizontal plane, not improved by constant massage throughout the voyage. In a third case the bullet entered below the right eye, and passed out to the side of the seventh cervical vertebra. The patient spat blood for three weeks, and his jaw was fixed. Now by massage he could open his mouth one inch and take convalescent diet.

B. *Chest.*—1. Penetrating (11). Six of these were shot through the right lung, the right side being of course the least dangerous. One was shot through both sides; and of the remaining four which entered the left side, three bullets were so far spent as to remain lodged, while the fourth traversed the left upper lobe just above and outside the pericardium. The hæmoptysis varied in duration and quantity from a teacupful to a quart in all, from three days to, at most, a fortnight. One man, probably typical of all, had a temperature of 100 degrees after two days, and once again of 99. But in one case an empyema developed, with pyrexia to 104 degrees, and a copious fœtid discharge. The lung was now expanding well. Another case, in which suppuration might have been

expected, was one of the most extraordinary cases met with in the campaign. The bullet had passed in at the left axilla, and was found subcutaneously in the right, with its nose upwards, indicating the resistance encountered from the elastic skin. No empyema followed, but a profuse surgical emphysema right down to the pelvis on the left side behind, and on both sides of the chest in front. There was profuse hæmoptysis at first, but the wounds healed primarily, and after five days, the patient—a young officer—said he had felt perfectly well. The report says that he had considerable cough and dyspnœa till a month after Colenso; but on board ship he was as active as if he were going out to the war; he could take a deep breath without pain, and he was only troubled with a deep cough, and by being occasionally overtired by his exertions. On examination there was good entry of air and only a slight general bronchitis discernible. In this, as in most cases, it appears that the bullet, by the force of its passage, seals the visceral pleura to the chest wall both at the entrance and exit of the wound. The wounds appear to granulate up in two or three weeks; and the only signs left are a slight bronchitis (if any) with some limitation of movement of the arm, owing to the scar formed by the bullet in pectorals or latissimus dorsi or scapular muscles. The cutaneous scars are usually free and soft. It must be added that auscultation is notoriously difficult and untrustworthy on board a screw-steamer.

C. *Abdomen* (5).—In these there was definite evidence of visceral penetration in the form of hæmatemesis, melæna, or hæmaturia varying in duration from one day to three weeks, one man, who was shot from side to side, having recovered after a fortnight's hæmatemesis and three weeks' melæna, with only slight pain on micturition, or taking a deep breath. The bowels have in most cases acted regularly from the first. One of these cases—one of the surgical triumphs of the campaign—had his bowel severed and perforated in eight places, and the abdomen full of blood, when he was operated on at Estcourt by Dr. J. G. Neale, Surgeon to the Johannesburg Hospital, eight hours after receiving the wound on November 27th. He had been carried over ten miles to the hospital; and had had no food for twenty-six hours. Fifteen inches of gut were resected, and the ends sewn together by Czerny-Lembert sutures. He was now practically well, eating solid food and walking about in a healthy way, with only a slight pain at times, due to damage of a small cutaneous nerve in the hip on exit of the bullet.

D. *Extremities*, 1.—Bones (37). In a few arms there was half an inch or so lengthening; and often considerable increase, up to an inch in circumference, from callus formed. In this the musculo-spiral was not infrequently implicated. The fractured legs and femurs could still bear but little weight on them, but improved notably with practice on board ship. A few had been kept in plaster too long, and were only released a few days before or after embarkation; but it was remarkable that even so they had a good range of movement, one man, for instance, with a fractured arm, after seven weeks in plaster, being able to flex and extend his elbow from an angle of 80 to 135 degrees. All these improved materially under systematic massage, and would have been still further improved by the administration of nitrous oxide gas for breaking down adhesions, as it was considered inadvisable to administer chloroform at sea, unless in case of emergency. On a future occasion this will probably be done. The hands of course presented a variety of local wounds, scar-contractions, severed tendons and nerves, nerves implicated in callus, and stumps insufficiently covered. Each of these was sufficient cause to disable a man from duty.

2. Joints (9). The swelling for the most part had almost disappeared, leaving some limitation of movement and pain on pressure, which cleared off well under massage, when this was available. Untrained massage was of comparatively little use.

3. Large blood-vessels (5). This included four aneurysms, respectively of the femoral, popliteal (2) and plantar arteries. The femoral aneurysms had been operated on by an incision nine inches long, and the thigh was in consequence painful, weak and tender. The others did not sensibly change during the voyage. The hum could be heard by the stethoscope from the popliteal space down either branch of the artery. In the fifth case, a bullet had damaged the femoral artery in a flesh wound, gangrene developed, and the limb had to be amputated at the seat of election. This was successful.

4. Large nerves (11). In one of the above cases of popliteal aneurysm the external popliteal nerve had been severed and had been united by operation. No improvement had as yet taken place in the useless limb. In the case of amputation just mentioned there was after the operation intense tingling pain referred to the toes, and morphia had to be given every night for five weeks. The nerves, it was thought, were implicated in the scar and would have to be separated. These symptoms, however, entirely passed away on board ship. Another case of injury to the sciatic nerve resulted in paralysis with throbbing pains in the feet. Under massage this improved steadily, slight movement returning by Jan. 3rd, with twitching movements of the toes. On the voyage, the pain cleared away but power did not return. The case in which a bullet lodged in the body of the fifth lumbar vertebra, presented at first almost complete paralysis of the left leg, but this cleared up so far as to allow good walking and only occasional bouts of shooting pain.

5. Uncomplicated flesh-wounds (52). These for the most part had left but very slight traces. Externally the scar in one typical case measured at entrance ·187 inch; at exit ·250 × ·750, the diameter of a Mauser bullet being about ·273. The entrance wound had obviously contracted in. The scars were frequently supple and free on the surface when the muscles beneath were still limited in their action. This limitation passed off to a large extent on use with massage, and the rest they had enjoyed for two months had not been entirely for their good. It was in hands, as much as in any part, that

real massage was of use, and it was here that scar tissue became troublesome. In a few instances large cutaneous wounds had been allowed to scar over without grafting, and trouble had already begun.

Besides gun-shot wounds there were a few contusions, one of which was interesting. A cavalry sergeant was thrown from his horse on Christmas Day, the horse falling across his pelvis, causing total loss of power in the legs, but not the viscera, and violent pains in all and especially the lower parts of the body. This pain passed off gradually, and slight power returned to the thighs, but the back was always very tender, and, without any direct evidence, it was thought the pelvis must have been fractured.

Other surgical affections included eight cases of hernia, three of synovitis of the knee, five of otorrhœa and deafness, three from ophthalmitis due to shell dust and from corneal ulcers, one of piles, one of varicose vein, one of boils, one of an old fractured thigh of last May, which caused trouble on the march, and one of an old fractured toe which gave similar trouble.

The thirty-nine venereal cases showed secondary and tertiary symptoms often brought on by the hardships of the campaign; while others were suffering from slowly developing strictures or from gonorrhœal rheumatism.

2. Of the medical cases there is little to say, in the absence of a weighing machine, the chief test of convalescence. It is to be hoped that the ships will in future carry a simple weighing machine and so allow careful records to be made.

a. Dysentery (71). As has been found on previous occasions, dysenteric cases profited markedly by the sea voyage. Experience of this dysentery shows that there is no distinction between the simplest diarrhœa with slight colic and the acute disease in which the bowels are open fifty or sixty times in the day or oftener, and the patients die away from sheer exhaustion. Whether this is a distinct and acute catarrhal dysentery as described by Osler, or a form of the tropical variety, it is difficult to say, and it has been difficult to make a systematic examination of the stools. But as to the treatment there is no doubt that the two essentials are rest and a light diet; and these were easily obtained on board ship. Further than this, bismuth and morphia in some form or other seemed the most useful treatment for the slight relapsing cases, although castor oil and opium at frequent intervals, ipecacuanha by mouth and by rectum, and sulphate of magnesia, were each found useful on occasion. Intestinal irrigation was impossible in the absence of a suitable long tube. An interesting fact brought out in the after-treatment was the effect of strychnine in irritating the intestine, a favourite tonic containing Liq. Strychi ɱii. having the almost invariable effect of causing the dysenteric symptoms to return. A tonic of Ferri et Quininæ Citratis gr. v. was substituted, and was fairly efficacious. Most of these cases came on board decidedly weak and still with occasional pains and two to eight liquid motions a day. They left it, with but few exceptions, sound and healthy men.

b. Rheumatism (44). Mostly cases of subacute rheumatism, giving an almost invariable history of exposure to wet and cold, followed within two days by the rheumatic pains and pyrexia to about 102 or 103 degrees. A few cases were probably in reality gonorrhœal in origin, besides those diagnosed as such, and it was at one time thought that the number included a proportion of malingerers. What seemed more probable in the end was that very few were real malingerers, but that several men, reservists especially, in the hope of getting home, had made the most of their real ailments, and it was impossible with certainty to distinguish reality from exaggeration. These cases also, on salicylates and iodide and a light diet, improved to a marked extent, and showed no complications of interest.

c. Enteric fever (9). Practically all but one convalescent, and that one died. None had been inoculated, and from their reports of cases in Maritzburg it would seem that the inoculated have been far less liable to catch the disease, and if they caught it, it has usually been of a mild type, although there was one striking example to the contrary. These enteric cases improved noticeably on the usual tonics.

d. Heatstroke (7). Except for one case already mentioned, these improved slowly but noticeably, although a persistent headache was often difficult to control, and was often brought on by exposure to sun even for a few minutes, or simply by the heat of the tropics.

e. Other medical affections (40), include the following:—Cardiac, 6; malaria, 5; simple debility and nervous exhaustion, 6; epilepsy and "petit mal," 4; cirrhosis, etc., 4; pleurisy and tubercle, 3; simple continued fever, 3; pneumonia, 2; dyspepsia, 2; bronchitis, 1; sciatica, 1; lumbago, 1; Bright's disease, 1; and Hodgkin's disease, 1.

F. E. F.

Nursing News.

Matron's Office.

LIST OF THE SUCCESSFUL CANDIDATES IN THE PHARMACY AND DISPENSING EXAMINATION.—March 26th, 1900.

Nurses H. Minshall, F. Pitman, Tompkins, J. Hughes, Akers, B. Daniels, Harradine, Graham, Ramsey, Seville, A. Allcock, Archdale, Lowenthal, Grassett, Heygate, Stanyon, G. Allen, Lamb, Whiteman, Wallis, V. Wood, Oldham, Hobbs, Pegler, Orr, L. Collins, Gibson, M. Wood, Morrah, Mallandaine, Micklethwait, Gale, B. Baker, Faulkner, Houstoun, Rainbow, Carey, A. Adams, Blower, Blayney, B. Collins, Ellis, Goodwyn, Mudge, K. Ray, H. Reeve, A. Warren, Bible, Neale, I. Wood, Hyde, Swadling, Sills, Jackson, Hayward, Hindley, Green.

Guy's in '55.

We are indebted to a correspondent for the following letters, which date from the middle of this century. The insight which they give of the manners and customs of student and nurse of the period forms a striking confirmation of the accuracy with which Charles Dickens pictured student life:—

Guy Street,
November, 1855.

To the Treasurer, Guy's Hospital.

Sir,—I trust you will not consider me troublesome or assuming in bringing under your notice the following:—

My wife, who for a womb complaint has been many years under the kind care of Dr. ——, was, for the purpose of undergoing an operation, admitted by that gentleman as an in-patient of Guy's Hospital, where he assured her she would have that care and medical advice her means did not permit at home. From a distressing operation there performed on Saturday last she was so upset that for a time she had to be moved away. It made her seriously ill, brought on inflammation and retching; she had to have on poultices and hot water to her feet. On the afternoon of Monday she was so bad the dresser had to be sent for twice. I am given to understand that when he came up in the evening he was accompanied by another student. They appeared to have taken more than proper, and commenced dancing the polka and singing "The Ratcatcher's Daughter," etc. My wife was scarcely kept from fainting by the kindness of the occupant of No. 9. To-day I find her very debilitated—more so than proper; can keep nothing on her stomach. The medicine that she should have to relieve her every four hours, she has had twice in the twenty-four, and a particular acid mixture that does relieve her is unobtainable. The mustard poultice put on her side last night was not dressed when taken off, and she was suffering therefrom until one of her friends went to her to-day and sent out for some spermaceti ointment to do it. She has every appearance of sinking from want of attention. I would have removed her home at once, but feared to do so before she once more sees Dr. —— to obtain his sanction. In the meantime, if you will have the kindness to cause enquiry as to the correctness of what I am led to believe, my purpose will be gained, as I am assured you will adopt means to remove any just cause of complaint by the friends of those who are so unfortunate as to require the benefit of the establishment under your supervision. It is but justice to the Sister and day nurse for me to add that Mrs. B—— expressed herself grateful for the attention of each of them as far as in their power lies. Not so the night nurse, who is much asleep while on her duty, and on Saturday night appeared in liquor. With an apology for so much troubling you, may I hope you will favour me in not communicating at present the receipt hereof to anyone until my wife returns to her home, and I shall remain, sir, yours truly obliged,

——.

Letter from the Assistant Obstetric Physician:—

To the Treasurer.

My Dear Sir,—At the request of Dr. Steele I accompanied him to the Hospital to investigate the outrage committed by one of the clerks of the Lying-in Charity.

The result was I advised him to resign. He has tendered his resignation, which I took myself to the Superintendent.

No such annoyance has occurred before, and I am truly grieved that so early in your magisterial duties you should be thus troubled.

It is true that on one occasion Dr. A—— was accused of running with a wheelbarrow at night. This charge was investigated and disproved.

Guy's Hospital Debating Society.

LADIES' NIGHT.

Saturday evening, March 24th, was the great night of the session. By the courtesy of the Governors the meeting was held in the court-room instead of in the smoking-room as heretofore. Dr. Pavy, as usual, took a night off in order to preside.

As a gathering of people the affair must be considered a great success, because the room was all but full. Many lady visitors were present as well as several Sisters and members of the nursing staff. As a debate the success was not so marked. After the familiar smoking-room the court-room reminded one of "another place," and the speakers, with of course some exceptions, appeared overcome by the awe-inspiring decorations.

The subject ought not to have been a heavy one since beer is always supposed to be exhilarating. "That in the opinion of this House the Government should be urged to take strenuous measures to prevent the wide-spread abuse of alcohol."

The minutes having been read, marked, and inwardly objected to, were after some additions and alterations finally adopted as correct, and the sign manual of the President was duly affixed. After some further inconsequent remarks concerning the secretary and the loss of a key, the public business was commenced by

Mr. E. H. Kitchen, who, in a speech worthy of the court-room, urged upon the Government the necessity of taking steps to prevent the abuse of alcohol. He was not a teetotaller, but he would ask the House to go with him into the jails and workhouses, and see how many of the inmates were there through the abuse of alcohol. He would not trouble the House with the statistics which he had prepared. (Hear, hear, from the opposition benches). He felt sure, however, after what he had said, that the House would shew its common sense, etc., by giving him a big majority.

Mr. J. M. Brydone maintained that Mr. Kitchen's arguments were really all in favour of the Opposition. (This does not seem to be quite a new idea). Why had

not Mr. Kitchen quoted the statistics he had prepared? Why should he have prepared them so carefully and then not dare to use them? He (J. M. B.) would tell the House. It was because Mr. Kitchen knew that they would damage the cause he had so much at heart. [It was at this period that he was called to order for haranguing Mr. Kitchen across the table.] He had between two and three thousand relatives and friends, and of this number only two or three (*i.e.*, 0.1 %) could be considered to abuse alcohol, hence the abuse was not widespread, ergo, there was no need of strenuous measures. He knew that he could rely on the common sense of the House, etc.

Then Mr. F. G. Gibson, of New Zealand (where the mutton comes from). He would shut up the houses, yclept public, which were not conducted in a becoming manner. There was a day in his life which was perhaps the proudest day of all, it was the day when he recorded his vote, soon after he attained his majority, in favour of closing certain low publics. In consequence of his vote the houses were very soon closed. He said other things and hoped that the House would shew its common sense, etc.

In a maiden effort Mr. P. R. Bolus settled the matter out of hand. He likewise settled the debate. If the President had not limited him to the regulation ten minutes, he would have appealed to the common sense of the House to vote on his side.

Mr. D. P. Watson felt sure the Opposition were not sincere, they had not the matter at heart; the Government must take measures, and he relied upon the House shewing its sense of justice in demanding that the Government, etc.

Mr. H. Wacher made an impassioned appeal on behalf of drink. The position of his opponents was untenable and it must be turned. He knew the House would turn it. Did Mr. Kitchen think that the House had not enough common sense to value his (*i.e.*, Mr. Kitchen's) arguments at their proper value. Mr. Kitchen would see.

Miss Thomas startled the House by saying that she was on the side of beer. The Government had no right to attempt such an absurd thing as the proposer of the motion suggested. People could not be made good by Act of Parliament; it was education, development of moral sense, etc., that made people good, and it was by means such as these that the abuse of alcohol would be put down.

Mr. Shufflebotham urged the House not to listen to men like Mr. Wacher and his accomplices, but to shew its common sense, and let Mr. Wacher know that it did not intend being dictated to.

Mr. Griffin, Mr. A. E. H. Pakes, and Mr. Thompson then held the floor successively, at the termination of which Mr. S. Hodgson took possession, and urged that the abuse of alcohol must be put down; he was a teetotaller because alcohol did not agree with him, he was also a volunteer, therefore it was not seemly that any one should abuse alcohol. He trusted that the House would shew its common sense, etc.

The President then called upon Messrs. Brydone and Kitchen for their replies.

Mr. J. M. Brydone } in reply, said that unfortunately
Mr. E. H. Kitchen } there had been no argument raised by any of his opponents which was worthy of reply. He would, therefore, throw himself upon the common sense of the House, and, relying upon the justness of his cause sit down fully confident that he would secure a verdict.

After the usual preliminaries the House shewed its common sense thus:—

For the motion	...	...	...	40
Against the motion	...	...	...	21
Majority for	...	...	...	19

Votes of thanks to Dr. Pavy and to the Governors having been passed, the House adjourned to coffee and biscuits.

Notices.

THE LONDON SCHOOL OF TROPICAL MEDICINE
Connaught Road, Albert Dock, E.

The Next Session will commence on Tuesday, the 1st May, 1900.

The Laboratories, Museum, Library, etc., will be open daily. The teaching will be carried out by systematic and clinical Lectures by the Visiting and Special Teaching Staff, and by daily Laboratory Instruction by the Resident Superintendent.

Clinical Instruction will be given daily in the Wards of the Hospitals.

Special arrangements for Board will be made for those who may desire to reside on the Premises.

A Travelling Scholarship of £300 is in the Gift of the School.

For Prospectus, Syllabus, and other Particulars, apply to

P. MICHELLI, Secretary,
Seamen's Hospital Society,
Greenwich, S.E.

Or to Dr. REES, the Medical Tutor, at the School.

INDIAN MEDICAL SERVICE.

An Examination for Commissions in Her Majesty's Indian Medical Service will be held in London in August, 1900.

Copies of Regulations for the Examination, with information regarding the pay and Retiring Allowances, etc., of Indian Medical Officers, may be obtained on application to the Under Secretary of State for India, India Office, London, S.W.

The exact date of the Examination and the number of Commissions to be competed for will be announced hereafter.

India Office, 15th March, 1900.

E. STEDMAN, Major-General, Military Secretary.

Passim.

It will be remembered that a meeting was held, some little time ago, to discuss the feasibility of organizing and equipping a Volunteer battalion composed entirely of medical students. A committee was formed and directed to communicate with other hospitals in London with the object of obtaining a general opinion on the matter. The result is exactly in accordance with the view which was taken by the senior men at the meeting; only one hospital treated the matter seriously, and this hospital definitely decided against the formation of a Hospital Corps. The unanimity with which the opinion is expressed that the existing corps are all-sufficient for our needs, leads us to suggest that the men who patriotically voted for a new regiment might, now that their project has proved unworkable, attach themselves in the ordinary way to one or other Volunteer battalion. But at the same time we must point out that no self-respecting corps will dream of accepting them on other than the usual conditions. The standard of efficiency is already so low that any further reduction would tend merely towards supreme uselessness; the increase in numerical strength would be more than compensated by the decrease in military fitness. In the National Drama, be it remembered, there must be no free list.

We were apparently wrong in stating that Surgeon Beadnell, R.N., had been attached to Lord Roberts' Staff. The latest report places his name on the list of officers who are returning home. In this connection the following extracts from the despatches of Admiral Sir Robert H. Harris, Commander-in-Chief on the Cape of Good Hope and West Coast of Africa stations, dealing with the work of the Naval Brigade from the date of reporting at Lord Methuen's Headquarters, to the action at Graspan, will be of interest. Captain A. E. Marchant, R.M.L.I., commanding the Naval Brigade reports: "Surgeon Beadnell, with the guns, did gallant and most excellent service under trying conditions, under fire nearly the whole time." And again, in the report of Lieut. F. W. Dean, R.N: "I found Surgeon Beadnell at Belmont Station; he had been invalided by a medical board that day, and was waiting for the hospital train. Though in bad health, he gladly accepted my order to remain with the guns in view of a pending engagement, and on Saturday he rendered invaluable aid to our wounded, working close up to the guns where shrapnel balls were showering every other minute."

Mr. Newland-Pedley, who is on the staff of the Imperial Yeomanry Hospital, has written a most interesting letter, from which we are privileged to make a few extracts. The site of the hospital is Deelfontein, "thirty miles south of De Aar Junction," and about the same distance from anywhere else. "We went on board a train that went up hill and down dale apparently at its own sweet will. After a day and a half the train climbed up here, about 4,000 feet above the sea, and deposited us on the primitive structure that represents our station. We could see some tents and niggers and packing cases and an ox waggon. We were glad to get a feed of any kind. I found a thing like a dog biscuit on the platform, and promptly consumed it. Our cook lit a fire and began to fry sausages, which he found in a tin. There were no knives and forks worth mentioning, so we dipped our fingers into the dish and put the sausages on chunks of bread and butter. We now have a good mess tent, a capital steward, good service and very good food. Col. Sloggett, R.A.M.C., has had any amount of experience, and although the difficulties to be overcome are great, every day shows an advance. The whole place is as busy as an ants' nest. Work begins at 6 a.m., and about that time you can see Col. Sloggett beginning his rounds, and sometimes you can hear him if he is not pleased.

"Mr. Fripp has returned to Cape Town to fetch the nurses, and I hope we shall be ready to receive them when they arrive, but they will have to camp in tents, because it is absolutely impossible to get permanent buildings constructed in a few hours. We are not putting up a few tents, but building a village round a big hospital. The site that has been chosen for us is exceptionally healthy, but when you have said that you have come to the end of it, for it is about as God-forsaken a spot as one could find. We are pitched at the foot of a hill about five hundred feet high, which helps to warm us when the sun is beating down on our heads. The rest of the country for miles round is a sandy waste, partly covered by low scrub. I have asked Mr. Greenfield to do me a sketch of our camp. If the Boers were to capture all our stores and were to carry off all the nurses into their mountain retreats, it would cause great inconvenience. I hope they would respect my dental instruments and appliances."—We hope so, too.

It would be an excellent idea if the hospital authorities were to provide some kind of receptacle for newspapers close to the front entrance; and perhaps a second within the college gates. Nearly everybody buys a paper nowadays, but the majority prefers to leave it in the railway carriage simply because there is no place at hand where it might be dropped for the use of the patients. There is certainly a box inside London Bridge Station close to the South London platform for this purpose, but it is not very obvious, and would only appeal to a limited number of our community. We feel sure that if a basket were placed in the colonnade, it would be sufficient to remind men that newspapers are very welcome in the wards, and there would be plenty of contributions. Another advantage would lie in the ease with which it could be emptied and its contents distributed; although we should miss the familiar sight of Victor on the Bridge steps staggering, like an Atlas, under his intellectual load.

In the new Front Surgery arrangements, the assistant house-surgeons score heavily. And this, without any detraction from the value of the true house appointments. Under the old system, the assistant house-surgeon in the Front Surgery was on duty from half-past nine in the morning till six at night. And from that time until half-past nine the next morning the taking-in house-surgeon and house-physician were responsible. Now, however, the assistant house-surgeon in the Front Surgery is on duty half-an-hour longer, and at half-past six in the evening, the corresponding assistant house-surgeon of the take-in comes on duty until relieved by the Front Surgery officer the next morning. The house-surgeon and house-physician for the week retain all their old control over cases admitted to the wards, but the assistant house-surgeon relieves them of the liability to be called to cases which do not require admission. During his week of office, the assistant house-surgeon is provided with lodging and partial board, but naturally he does not constitute an increase in the number of the Residents. Considering the experience which this new work entails, it is a very valuable addition to the duty of an assistant house-surgeon.

The award of the Physical Society for the best papers read at its meetings during the session, has been made as follows: Mr. F. G. Gibson secures the premium of ten pounds for his paper on "Cancer of the Tongue," while to Mr. Frank Cross falls the second prize of five pounds for his paper on "Abdominal Injuries." We offer these gentlemen our hearty congratulations on their successes. In our next number we shall publish the first part of Mr. Gibson's paper.

We have received the third number of a new Quarterly Journal of Health and Travel, which bears the somewhat indefinite title *Climate*. Perhaps the known vagaries of our own especial climate have led the editor of this journal to fix on a title which will give him the greatest scope in the choice of subject-matter. At any rate, the contents of this particular number are very varied, but none the less interesting. An article on "Gardening in West Africa," contains several well executed reproductions of photographs by Dr. Crosse, of West African fame, and is a very excellent little brochure on the horticultural potentialities of the country. An interview with Dr. Hillier, of the Loch contingent committee on the hygienic view of the South African crisis, is of value if only for the very definite statements which it contains with regard to clothing in South Africa. The following extract will appeal to those at all interested in the Imperial Yeomanry and kindred services. Referring to the equipment of a man on active service, Dr. Hillier says:

"There are various points which are worthy of special note. Perhaps the most important thing is to have a good blanket, and see that it is large enough. Eight feet by six feet is none too large. Many find it convenient to substitute for the blanket a sleeping-sack. As regards head dress, there is nothing to beat a broad-brimmed felt hat for the South African veldt. It is much better for men on active service than a helmet, for with the felt hat they can lie down in it, whilst a special place must be found for the helmet. For use at night the men of the Loch Contingent were provided with a woollen fisherman's cap, provided by Jaegers.

"As an overcoat the dark blue or grey cavalry cloak is much better than the khaki colour, as it would only be wanted at night and then would be less easily distinguished. On the other hand, a soldier should have a khaki-coloured woollen shirt, as he may patrol or fight in his shirt. One of the most useful articles of dress is a sweater. It can be worn at all times, and is a great protection against chill. This may also be khaki-coloured.

"Our committee were also averse to the use of putties of serge or any kind of soft cloth, as they are likely to catch in the grass of the veldt, which is known as stick grass, and is similar to what is known as spear-grass in other countries."

The St. Mary's Hospital Gazette has published a special sports supplement, containing, among other things, photographic groups of the members of their victorious teams. We congratulate St. Mary's on making such an excellent show this season; above all we congratulate them on winning the coveted "Rugger" Cup, for the first time, we believe, in their history. Lastly, we congratulate them on the extremely sportsmanlike account which they publish of the Semi-Final, in which we were defeated by a goal to nil, and thank them for their courteous appreciation of our team and of individual members. We hope we shall meet them again in the competition next year, and perhaps win back the trophy for our smoking-room.

We congratulate Mr. Graham Simpson on a double event; firstly on his election to the Presidency of the Residents, secondly on his election to the Senior Proficiency Prize. Mr. Carter was runner up in the first, Mr. E. Cohen in the second event. The Junior Proficiency Prizes were won by Messrs. P. R. Bolus, Milsom, and Spriggs, and the Wooldridge Memorial Prize by Mr. P. R. Bolus. To all of these gentlemen the Gazette offers its congratulations.

The work of rebuilding and enlarging the front surgery has now definitely commenced. At present a number of workmen are engaged in excavating in front of the surgery for the foundations of the future front wall which is to be in line with the main entrance to the hospital. Recent work among the foundations of the surgical buildings has revealed the curious fact that the whole of "Guy's House" rests on wooden piles, and also shows, in one instance, at least, that the jerry builder was not unknown even in the days of Thomas Guy. Advantage has been taken of the vacation to complete the asphalte floor in the Public Health Laboratory, and to put in the remainder of the new benches; at the same time the laboratory will be wired for the electric light, but will not receive power until the hospital generating plant is laid down.

In another column will be found a brief notice to the effect that the Medical School has again received nominations for Commissions to the R.A.M.C. The reason of this is doubtless to be found in the war, which every day makes the necessity for additional medical men in the Service more urgent. It is a pity, however, that nomination is not regularly used as a means of filling vacancies in the R.A.M.C. Were this the case, it is conceivable that a relaxation of the rigid system of examination for qualifications, medical and surgical, might follow, and the giving of diplomas relegated to the Medical Council of the School in which a man is trained. There can be no doubt that the best estimate of a man's capabilities for independent practice is to be obtained from the teachers with whom he has worked; and, while the existing examination system occasionally approves of incompetency, and rejects undoubted merit, qualification by nomination would reduce the chances of such mistakes to an inappreciable minimum. But the love of inquisitions is so deeply ingrained in the hearts of the British public, that it is to be feared any innovation along such lines as these would encounter irresistible opposition, and would be doomed to failure from its inception.

The combined Choral Societies were not satisfied with the laurels achieved at their annual concert. They aspired to greater things and thought to reap honour in the field of sacred music. So the practices went on Friday after Friday, with the hoarse basses and the puling tenors desiring wings of doves, at five o'clock, and the harmonised four voices panting for water brooks at eight. Expectation ran high and was kept alive by the extraordinary mystery surrounding the time, place, and nature of the performance. Perhaps, though, the nature was a little more obvious; at any rate, the date and location were shrouded in mystery. Now there would be a practice with harmonium, suggestive of the chapel, now with the piano, suggestive of the court room, and again with piano and harmonium, suggestive of anything. So the time passed, and at last the riddle was solved. There is not going to be a performance at all. *Exeunt omnes.*

The Illuminated Address to Mr. Davies-Colley, is now within measurable distance of completion. The last of the six hundred odd signatures has been copied in, and the "bit of parchment" now lies in the hands of the binder. As most of the signatories will be glad to see the original address, we have arranged that it shall be on view in the office of the Secretary to the Treasurer next Friday and Saturday. In the event of some unforeseen circumstance, such as a strike, war, the act of the Queen's enemies, or the visitation of providence preventing the due exhibition of the address as promised above, we

hereby give notice that we will not be held responsible for any moral or intellectual loss that may result therefrom. And we also give notice that we shall *not* be prepared to receive suggestions, alterations, or corrections dealing with the address, and that we shall deem all such suggestions, alterations, or corrections as unfriendly acts.

The Pupil in Health and Disease.

A Paper read before the Physical Society on Saturday January 20th, 1900, by Mr. C. T. Hilton.

(*Concluded*).

The pupil in death.—(Finlayson). Immediately after death the pupils are usually moderately dilated owing to the relaxation of the sphincter, while there is a tendency to contraction later. Atropine, if put in soon after death produces dilatation, though not so widely as during life. Sometimes it is only strong enough to prevent the subsequent contraction. After four to six hours, atropine loses its effect; it may act even after rigor mortis is established, which is of interest since the contraction after death, looks as if it might be due to rigor mortis. The action of atropine after death passes off in twenty-four hours, and the pupils will be found equal and contracted. If the subject were alive the action would have lasted for three or four days. This action of atropine is probably due to its power of stimulating the dilator fibres. The size of the pupil after death is no indication of its size just before death, and if before death the pupils were unequal, after death they will be found equal, unless the inequality be due to adhesions. The iris is flaccid, and if pressure be made on either side of the sclerotic towards the middle line the pupil becomes oval. In a living person the pupil remains circular, though in a few cases it has been observed to become oval on pressure in severe collapse, but only within a few hours of death. The iris is never as flaccid in life as in death. In cases of catalepsy, a trance simulating death, the pupil reacts to light and dilates in the dark. In real death the pupil is not affected by light.

The Pupil in Disease.—Schneideman, whose classification I have mainly followed, says that the direct effect of a bright light on the iris may disturb the equality of the pupils, if the illumination of the two muscles be unequal. The reactions of the pupils should be examined in both weak and bright light.

The hemianopic pupillary reaction. When light falls on the blind half of the retina in hemianopia, the pupil contracts, if the disease is in the hemisphere, just as if it had fallen on the functional part of the retina, but it contracts much less if the disease is in the tract, because the path to the corpus quadrigeminum superius is interrupted. To carry out the test with certainty, great care must be taken that the light is thrown in obliquely, and falls on the retina some way from the macula. The conclusions to be drawn from this are:—(i.) That softenings or tumours involving the optic radiations do not give this reaction unless indirectly by pressure on the optic tracts, (ii.) lesions of the optic tracts, whether involved directly, or by pressure from a distance, are accompanied by this reaction, (iii.) lesions of the basal ganglia—external geniculate body and pulvinar—do not necessarily give rise to this reaction. Frequently associated with it, but merely by secondary implications of the tract fibres, hemianopic pupillary reaction is observed in bitemporal hemianopia, occurring in acromegaly and other affections of the optic chiasma. In a case of left-sided, monocular, temporal hemianopia due to fracture through the optic foramen, the hemianopic pupillary reaction was present in the left eye.

The consensual pupil reaction is of great value, for by it we can gauge the condition of the commissural connections, and intercommunications between the centres and the afferent and efferent limbs of the reflex arc. For instance, *direct reflex* pupillary immobility in one eye may be associated with a consensual contraction of that pupil when light is thrown into the other eye; this shows the intact state of the pupillary contraction centres, and of the commissural fibres between them. If both *direct* and *consensual* reactions are abolished in one eye the lesion is limited to the centre for the sphincter iridis, or to fibres arising therefrom on one side, which is the only site where blocking of both direct and crossed pupillary fibres is possible, supposing the lesion to be single. If when in homonymous hemianopia from lesion of the optic tract, light be thrown into the functional half of one retina, both pupils contract. This reaction suggests both a semi-decussation of pupillary fibres at the optic chiasma and a free communication between the opposite pupil contraction centres.

Anatomical classification.

1. *Spasmodic mydriasis* (irritative).—When there is an initiative lesion in the upper part of cord or irritation of sympathetic in the neck. Pupil reacts to light, accommodation and convergence are preserved. Faradic excitation of the skin does not cause increased dilatation. Atropine and cocaine may increase it. Eserine has little effect. Generally also there are proptosis, dilatation of palpebral fissure, increased secretion of tears, pallor on one side of face, etc.

2. *Paralytic mydriasis*, due to paralysis of third nerve nucleus or under conditions of great intracranial pressure. Reactions to light, accommodation and convergence are abolished. Accommodation to vision is lost. The pupil is moderately dilated, cutaneous and sensory irritation may increase it. Atropine and eserine have no effect. Cocaine increases it by stimulating the sympathetic.

3. *Spasmodic myosis*, due to irritation to pupillary fibres of third nerve as by early cerebral tumour, meningitis, cerebral abscess and pontine hæmorrhage. The pupil is strongly contracted, hardly responsive to the strongest stimulation by light, accommodation or convergence.

Atropine and eserine have no effect. Cocaine sometimes causes dilatation. There is spasm of accommodation also.

4. *Paralytic myosis*, due to inhibition or paralysis of sympathetic, *e.g.* in tabes, general paralysis of the insane, and some forms of cerebral syphilis. Pupil is contracted, reaction to light and convergence may be preserved. Cocane and atropine dilate the pupil, and eserine will contract it after such artificial dilatation. Cutaneous and sensory excitation have no effect. Accommodation is unaffected. There is also contraction of the palpebral fissure, retraction of the globe, diminution of tears, vasomotor phenomena, *e.g.*, congestion of one side of face, etc. In affections of the cervical sympathetic the pupil is less contracted than in disease of the cervical portion of the cord with paralysis of the sympathetic, probably because some dilator fibres go straight to the eye with the fifth nerve.

The etiological classification.—The etiologic diagnosis of inequality is the only one of value for prognosis, the pathological pupil being the one that reacts sluggishly or not at all. As a rule inequality from paralysis of the third nerve might be thought to be hopeless, but it may be functional though it is rare. Inequality due to irritation of the third and sympathetic indicates a better prognosis. Inequality may be either (i.) *organic* due to a lesion, (ii.) *functional*, generally affecting the sympathetic indirectly, only very rarely affecting the third nerve, and (iii.) *physiological*, already mentioned.

5. *Organic.*—Lesion may be in eye, orbit, cranium, spinal cord or elsewhere.

a. Intra-ocular.—Hyperæmia, the result of cerebral congestion, causes contraction. Haldane states that the size of the pupil is the best guide as to the state of circulation through the brain. *Anæmia*, the result of contraction of the cerebral vessels causes dilatation. *Diphtheritic paralysis* produces sluggish light reflex and loss of power of accommodation and of associated action of the iris. Associated paralysis affect intrinsic and *some* of extrinsic muscles, not all. A blow on one eye may give rise to unequal pupils from paralysis of the sympathetic or third nerves, or the pupils may be unequal from the local application of a drug. There may be paralysis following a rheumatic or syphilitic inflammation of the eye.

b. Intra-orbital.—Hutchinson says that in some cases of syphilis the pupil is about the normal size but absolutely motionless, and with no defect of ocular muscles; these cases he thinks to be due to destruction, temporary or permanent, of the ciliary ganglion. In cellulitis of the orbit the pressure of the inflammatory products may cause paralysis of the third nerve. Orbital growths causing pressure paralysis are rare. Impairment of the sight in one eye without any affection of the other, and with loss of action of the pupil, is due to disease of one optic nerve. If the nerve is partially destroyed, the characteristic feature is the dilatation which occurs after the contraction on exposure to light, though the light is still falling on the eye. A boy lately in John ward with old optic neuritis and atrophy, the result of a cerebral tumour, showed this reaction.

c. Intra-cranial.—In *sudden anæmia* of the brain the pupils are first contracted and the patient is drowsy, weak, and pale, with cold skin, vertigo, nausea, and sighing respiration. This contraction is probably due to irritation of the third nerve iris centre. Later the pupils dilate, due to paralysis of the centre, and the patient is in a condition of coma which deepens to death. The pupils may show the same changes in young children after exhausting discharges, *e.g.*, diarrhœa, etc. Such symptoms have been called hydrocephaloid from their resemblance to those of acute hydrocephalus.

Hyperæmia of brain.—In children symptoms occur which resemble meningitis though no evidence of inflammation is found post-mortem. The pupils are unequal. If congestion of the brain is the cause it is probably that which constitutes the first stage of inflammation. Tumours of nerves are rare. One third nerve in cases of syphilis may develope a gummatous node on it, in its course to the orbit, and this will produce unequal pupils; there may be total ophthalmoplegia or it may be only partial, the intrinsic being involved with any or all of the extrinsic muscles.

Werniche reports a case of total blindness caused by a tumour in the occipital lobe on the left side, while the right optic tract was compressed by an enlarged vein. There was no perception of light, but both pupils reacted to light (diffused). But if light only fell on the right half of either retina no effect followed, though they reacted if the light fell on the left halves of either retina. By this means the lesions were localized. This condition must be very rare.

Acute lesions of the corpora quadrigemina superiora cause loss of action of the pupil and possibly loss of sight.

In *cerebral hæmorrhage* the pupils may be affected though the lesion is situated some way from the third nerve nucleus. An inequality of the pupils denotes little more than some cerebral trouble. An extreme dilatation or contraction, especially if the light reflex be lost, denotes a serious affection of the brain. In cases of a large hæmorrhage into the substance of the brain the pupil on that side is often larger, and sometimes both eyes are forcibly turned away from the paralysed side. If the hæmorrhage be into the ventricles the pupils are widely dilated and fixed; if a child is thought to be asleep but has fixed widely-dilated pupils it is indicative of ventricular hæmorrhage. If the ventricular hæmorrhage be greater so as to press upon the base of the brain the pupils are minutely contracted. This is a very bad sign. If hæmorrhage be into the *crus cerebri* it may cause crossed paralysis of the third nerves and limbs. We then have a dilated pupil on one side and paralysis on the other. A hæmorrhage into the crus often paralyses both third nerves. In hæmorrhage into the third nerve nuclei, the ophthalmoplegia may be partial or complete. If partial, the paralysis is dissociated, the intrinsic and some of the extrinsic muscles,

or all the intrinsic alone, but never all the extrinsic alone. This is explained by the separate blood-supply to the superior and inferior parts of the third nerve nuclei. The third nerve nuclei are often affected as their arteries are under fairly high blood-pressure, pass vertically from the main vessels, and are all terminal. The corpora quadrigemina are said never to be the seat of limited hæmorrhage, therefore the loss of light reflex without paralysis of the third nerve cannot be due to hæmorrhage into the superior corpora quadrigemina. In hæmorrhage into the pons the pupils are generally minutely contracted, and, as in opium poisoning, they are fixed. Occasionally they may be dilated and fixed. The temperature is often high in pontine hæmorrhage. In *cerebellar* hæmorrhage the pupils vary, but if large they are usually contracted, as in pontine hæmorrhage. In one case of hæmorrhage into the cerebellar fossa the pupils were minutely contracted, resembling in this respect pontine hæmorrhage.

Cerebral embolism.—Acute softening: Embolism of the basilar artery is the only case in which the pupil would be affected. It is a rare condition. The pupils may be contracted or dilated, and the light reflex lost; sometimes this condition is transient. Sometimes, also, there is paralysis of the whole or part of one or both third nerves.

Thrombosis of the cavernous sinus is the only lesion of this kind that often affects the pupils. It causes a fixed and dilated pupil on the same side, and also proptosis, and more or less blindness. The symptoms later on affect the other eye, and these symptoms and sequence are distinctive. If seen early there may be myosis at first.

Cerebral tumour.—Isolated paralysis of the whole of one or both third nerves occurs only with tumours of, or adjacent to, the crus cerebri, and first appears on the side opposite to the hemiplegia, which also is present. Both third nerves may be affected by an interpeduncular growth. Partial paralyses usually involve the levator palpebæ or internal rectus muscles. Combined paralyses of the ocular muscles, slight and various, occur with tumours of the deeper parts of the hemispheres, corpora quadrigemina, pons and basal tumours. All the muscles of one eye are paralysed only by growths in the neighbourhood of the sella turcica, and there is then usually loss of sight also. Unequal pupils are often present, but that alone is not of much value in determining the nature of the lesion, but may aid in localising it. If the tumour be left, the symptoms increase. In one case (Gowers) in which there was paralysis of iris and other symptoms of cerebral tumour, all the symptoms except the headache cleared up for three years; the patient then died suddenly, and a degenerated tumour was found in front of the valve of Vieussens. Lesions at a distance from the third nerve nucleus may cause unequal pupils; this may be due to lesion of third nerve, but also may be the result of lesion of the sympathetic or fifth nerve.

Cranial aneurysms.—Aneurysm of the internal carotid in the cavernous sinus presses upon and paralyses the third nerve; this distinguishes it from aneurysm of the anterior cerebral, which produces the same symptoms with this exception. Aneurysm of the internal carotid also presses upon the ophthalmic division of the fifth nerve, and if it caused paralysis also, the pupil might not be so dilated. Aneurysm of the posterior communicating artery presses upon and paralyses the third nerve, producing dilatation of the pupil. This would not affect the ophthalmic division of the fifth. In aneurysm of the basilar artery the third nerves are rarely affected, but the fifth to the tenth are often compressed. Aneurysm of the posterior cerebral presses upon the third and sixth nerves, and generally produces hemiplegia in addition from pressure upon the pons or crus.

Cerebral abscess.—The pupils may remain normal for some time if the abscess be small and situated some distance from the third nerve nucleus or the nerve itself. When the abscess is situated in the temporo-sphenoidal, or frontal lobe and is small, it causes cerebral irritation, and the pupil is contracted and sluggish. When the abscess is large it causes pressure effects, and produces a dilated and stabile pupil. Often the only phenomenon is sluggishness of one pupil to light and accommodation, the other being normal. An infected injury to the skull, or unilateral otitis media, and a sluggish pupil on the same side, with myosis or mydriasis, points to an abscess on that side. The third nerve may be paralysed by the pressure of a large abscess in the temporo-sphenoidal lobe, and then there is a fixed and widely dilated pupil on the same side. If both third nerves show paralysis, it indicates a very large abscess. In two cases of advanced cerebellar abscess and meningitis the pupils were widely dilated, and there was optic neuritis and blindness with defective ocular movement.

In meningitis.—In general cerebral meningitis both eyes may be affected equally and they are then contracted, especially when there is intolerance of light; later, when pressure symptoms supervene, both become dilated and fixed. If the meningitis is localized to one side, inequality of the pupils is a very common and most important symptom. It occurs in inflammation of the convexity as well as of the base. It is often transient and variable, present at one time and absent a few hours later, first in one eye and then in the other. The dilator fibres are unduly sensitive to cutaneous stimulation. In tubercular meningitis the ocular symptoms appear after one week. Inequality of the pupils is, at first, associated with headache, slow pulse, some retraction and rigidity, some temperature, and a sleepy condition. Later with coma, convulsions, quick pulse and a variable temperature, the pupils get dilated and fixed. In the early stages inequality of the pupils may be the first ocular symptom.

Hydrocephalus.—If the pressure gets acute the pupils are dilated from pressure upon, and paralysis of, the third

nerve. In one case a child was comatose, almost paralytic, with strabismus and dilated pupils. The ventricles were tapped and the child kicked, the strabismus ceased and the pupils contracted.

Toxic conditions, e.g., uræmia.—The pupils are usually dilated and may or may not react to light. Gowers states that he has seen them contract during the fit and dilate afterwards. Macewen says they are contracted during the coma. Haldane states that if the pupils are contracted in uræmia it is an indication that the cerebral circulation is congested, and therefore the patient ought to be bled.

Epilepsy.—The pupil is occasionally contracted at the onset of a fit, but such contraction is certainly not invariable. When the tonic stage is well established the pupils are dilated and continue so until the fit is over. The iris does not contract to light; when signs of consciousness can be elicited the dilatation ceases. After the tonic spasm has passed away there often appears to be an epileptic fit of the iris. It dilates to the utmost and then contracts rhythmically for two or three minutes. The movements are slower than those of the voluntary muscles but are of the same character. Dr. Clouston says that in conditions of the pupil in insanity, that of permanent contraction is the most unfavourable.

General paralysis of the insane.—The commonest condition of the pupil is that known as the Argyl-Robertson pupil, with inequality. They may be unequal, small, and react sluggishly to light and accommodation. Duchenne records a case with contracted pupils which dilated when the patient had lightning pains. Wood has observed in the convulsions a movement of the iris irrespective of stimulation by light, etc., and the contractions were often irregular, so that the outline of the pupil was no longer circular but oval. One observer is so impressed with the importance of the Argyl-Robertson pupil as a diagnostic factor in general paralysis of the insane, as to state that any case of doubtful mental alienation with Argyl-Robertson pupil is a case of general paralysis of the insane, except the rare cases of tabes, in which mental symptoms have been superadded.

Exophthalmic goitre.—Inequality in size and slight irregularity in the form of the pupils have been sometimes met with in this disease.

d. Intervertebral.—Is always due to sympathetic lesion The effect being greater if the lesion be in the cord than if it is outside, because of the fifth nerve. The blood-supply of the cord is much poorer below than above, and the posterior columns are worse supplied than the anterior.

In *leptomeningitis* the action of the heart is sometimes deranged, and contraction or dilatation of one or both pupils may occur.

In *Laudry's Paralysis* (acute ascending) in rare cases there may be loss of accommodation, inequality, or dilatation of pupils.

Locomotor ataxy, or tabes dorsalis, the classical pupil symptom is that known as the Argyle-Robertson pupil, which was first accurately observed and described by Professor Argyle-Robertson, of Edinburgh, in 1868-9. The pupil symptoms in tabes are very important, as they often occur very early in the disease, often before the knee-jerks are lost, or any difference can be noted in the gait. In the early stages, before the light reflex is lost, this condition may not be maintained, the pupil again enlarging after the reflex contraction on bringing a light before the eye. In this case the reflex sensory dilatation is also present. Sometimes the pupil is medium sized or even moderately dilated, and then the skin reflex can generally be obtained, though not the light reflex. In advanced cases the pupils are contracted, insensitive to light and sensory reflex. Accommodation and the associated contraction of the iris are, however, preserved. Very rarely there is loss of accommodation, with perfect reaction to light. If the associated reaction is lost, the power of accommodation for sight is also lost, and the pupil may be moderately large. The pupils are not necessarily circular, and they are often unequal. They may not be affected to an equal extent. The Argyle-Robertson pupils are of value in joint disease in the differential diagnosis between the Charcot of Tabes and of Syringomyelia. Money thinks that cases of Argyle-Robertson pupils with dilated pupils, may be due to the intense light and heat acting on the fifth nerve in the conjunctiva in the same way as stimulation of the skin produces dilatation. In these cases pinching the skin generally produces some dilatation. The contraction of the pupils is generally regarded as due to interference with the cilio-spinal fibres from the cord, they being involved in the sclerosis of the disease. Turner says that the Argyle-Robertson pupil may be due to changes in (i.) the peripheral nervous or muscular apparatus of the iris; (ii.) the afferent or efferent limbs of the reflex arc; (iii.) the central mechanism situated in and around the grey matter of the aqueduct of Sylvius, *i.e.*, either the cells in the anterior part of the nucleus or in the fibres connecting the oculo-motor nucleus with the optic tracts. If the cilio-spinal fibres are involved where they leave the cord, and also there is loss of light reflex, then, either the phenomena are due to a double lesion or to a very extensive degeneration. Where there is no evidence of involvement of that part of the cord in which the cilio-spinal fibres lie, we are forced to the conclusion that both are due to a lesion where the pupil-dilatation and pupil-contraction centres are situated, *i.e.*, in the front and outer part of the anterior nucleus of the third nerve. Turner thinks that the change in the pupil reflex is due to a central change, and that it points to an early progressive degeneration of the upper portion of the central nervous apparatus. The pathology of this condition is still a matter of doubt. One explanation is that the fillet is early sclerosed in the region of the corpus quadrigeminum superius, and that this sclerosis involves the fibres running to the oculo-motor nucleus. Dr. Pitt says, that in his opinion, it is due to arterial degeneration, and that the reason why the light

reflex goes so early is that it is one of the most sensitive and active reflexes of the body, and, therefore, its centre is most likely to suffer from any diminution in its blood-supply. The dorsal part of the cord is also the worst supplied with blood, and is, therefore, the first to undergo sclerosis when the arteries which supply it become degenerated. In relation to this theory it has been noted that the posterior columns of the cord, especially in the cervical region, have been degenerated in cases of cerebral tumour. The pressure of the tumour forces the brain down into the foramen magnum, and so presses on the posterior spinal artery, thus causing anæmia of the upper part of the posterior columns, and so degeneration. Again, a history of syphilis is very common in tabes dorsalis, and syphilis is a very important cause of arterial degeneration, so that the primary lesion might be in the form of a syphilitic endarteritis.

Primary spastic paraplegia.—The action of the pupils is usually perfect. In *ataxic paraplegia* the pupil usually acts to light, but occasionally the light reflex is lost. Gowers records a case in which accommodation was lost, the reaction to light being normal. *Hereditary ataxy.*—A few cases have been recorded with loss of light reflex. Dr. Pitt thinks the disease is due to arterial degeneration (hereditary). *Progressive* (chronic) *muscular atrophy.*—The reflex action of the iris is usually normal. Frequently dilatation or contraction of one pupil has been observed, generally in association with atrophy of the muscles supplied from the lower part of the cervical region, and depends on disease of the cord and not of the sympathetic itself. *Tumours* of the cord may affect the sympathetic; they do not alter the light reflex. *Syringo-myelia.*— The pupils are often unequal, the smaller being on the side of the severer cord symptoms, where the sympathetic fibres for the radiation muscle of the iris are likely to be damaged. *Traumatic lesions* may affect the sympathetic fibres.

Insular sclerosis.—Pupils sometimes unequal, reflex action of iris hardly ever lost.

Injuries to the *spinal cord* may cause unequal pupils. Thus, in one case recorded by Ogle, with extravasation of blood into the cord opposite the fifth and sixth cervical vertebræ, both pupils were greatly contracted, the patient was sensible and showed no cerebral symptoms. Another case of fracture dislocation of the lower cervical and upper dorsal vertebræ showed contraction of both pupils; post-mortem, the cord opposite the site of injury was found red and congested. In a case of fracture of the fourth and fifth cervical vertebræ, both pupils were contracted, the cord was found swollen and softened, and there was some extradural hæmorrhage. In one case of fracture with complete loss of power in the right leg, partial loss in the left, both pupils were found contracted, but the right was the smaller. Another case of fracture dislocation in lower cervical and upper dorsal region, showed contracted pupils. These results of injury in the human being correspond to the effect produced by experimental division, ligature or pressure on similar parts of the nervous system of the lower animals.

e. Extra-cranial.

Aneurysm.—The pupils may be unequal. The inequality occurs from interference with the sympathetic. The pupil then reacts to light and accommodation; and atropine and eserine also produce their effects. Generally, the pupil on the affected side is contracted from paralysis of the dilator, and so the third nerve has free play. When it is larger on the affected side it points to irritation of the sympathetic; occasionally it is at one time larger, at another smaller. Gairdner records a case of aneurysm of the aorta, which had eroded the bodies of several vertebræ in such a manner as to involve the cilio-spinal branches on both sides and caused stabile myosis; usually only one pupil is affected. An aneurysm which produces a permanent and well-marked contraction, or perhaps, in rare cases, some degree of much less permanent dilatation of the pupil on one side, may be expected to arise from the upper and back part of the arch or its primary branches, the sac projecting back so as to implicate the sympathetic trunk or its ganglia, and in most instances also the vertebræ (lower cervical and upper dorsal), so as to intercept the nervous communications passing from the spinal cord in these regions to the sympathetic. Associated with the dilated or contracted pupil there is generally unilateral sweating of the face, increased secretion of tears and flushing. Aneurysms of other arteries besides the aorta may produce unequal pupils. In a case of aneurysm of the left carotid the left pupil was noted to be contracted, the artery was tied, and the tumour diminished in size, and in eight days the pupil had almost recovered its natural size. In one case of aneurysm of the aorta both pupils were dilated, but the left more so, both reacted to light, and both contracted when the patient was asleep, but the left always remained the larger.

Tumours of the thorax or neck if they involve the sympathetic may cause either dilated or contracted pupil. In a case of enlarged glands on the left side of the neck the pupils were at first equal but as the glands enlarged the left pupil became contracted, and post-mortem the glands were found pressing on the sympathetic. In another case of malignant growth which had infiltrated the deep structures, and involved the sympathetic, the pupil on the same side was found dilated. In a case of cervical adenitis after scarlet fever, both pupils were fixed and dilated but the left more so, and at the autopsy the induration and matting were the more marked on the left side. Another case of a tumour in the left lower triangular space of neck, the left pupil was contracted and the eye partly closed; the sympathetic was found to be involved. Another interesting case mentioned by Ogle was that of an abscess on the right side of the neck, the right pupil was very dilated, the patient was given opium to relieve the pain and went to sleep and on awakening the pupil was normal. Later patient had a rigor and the pupil was now contracted, pain followed and the pupil dilated. This was observed

several times, the iris was also observed to have acquired a dark brown tinge due to alterations in size of the capillaries. After the abscess was opened the pupil remained dilated, but contracted under light. As the neck improved the pupil regained its natural size. The pupil here behaved as it would to stimulation of the skin, dilating when the patient was in pain and contracting when the pain was relieved, but the changes were only observed on the side on which the abscess was situated and not on both sides as is usual in the sensory reflex. Ogle does not mention the sensory reflex dilatation though he records dilatation of the pupil from the irritation of worms, and in cases of burns, scalds, mechanical injuries, etc., and thinks, that they are comparable to the influence of the sympathetic on the heart causing palpitation. Osler states that the sympathetic may be involved in the contraction following a pleurisy at the apex and so may give unequal pupils, unilateral sweating, etc. In some cases of pericarditis the pupils may be unequal, the pathological one being usually the left. There may be unequal pupils in heart lesions, but most likely these are functional. A patient has recently left Miriam who had mitral stenosis, and whose right pupil was larger than the left, while both reacted to light, etc. This may be functional, due to the heart lesion or may be one of Osler's pleurisy cases, as patient states that she had severe pain in the right side of her neck some time before admission when she was "bad with bronchitis." But there is no unilateral sweating or flushing so that it is probably functional. Tubercular disease of the left apex, apical pneumonia, and pleuro-pneumonia generally cause organic inequality due to implication of the sympathetic. Brown-Sequard says that removal of the suprarenal is often accompanied by contracted pupil on the same side, probably on account of the close connection with the sympathetic nerves.

Functional inequality is generally due to irritation of the sympathetic, *i.e.*, is a unilateral spasmodic mydriasis. The inequality is often only evident when the pupils are dilated, as a strong light may cause contraction and make them equal; in these cases, therefore, the inequality is intermittent. When two diseases are present, an acute on one side and a chronic on the other, the larger pupil is on the side of the acute affection. This inequality, if latent, is made manifest by faradising the skin of the forehead. Pasternatski made some observations on the pupils in disease; he found unequal pupils in 85 per cent. of pneumonias (lobar), 61 per cent. heart and aneurysm cases, 52 per cent. of pleurisy, 38 per cent. of chronic broncho-pneumonia, 25 per cent. each of acute rheumatism und bronchitis, 16 per cent. each of scurvy and typhus, and 13 per cent. of typhoid. Also in about half the cases of catarrhal and hepatic jaundice and renal colic. The largest percentage was in lobar pneumonia, at the onset of the attack the pupil on the same side was the larger; the difference increased with the inflammation till the third, fourth or fifth day. Before the crisis the difference diminishes and may even disappear. During the stage of resolution the pupil on the affected side is smaller, being now contracted. There is a difference also in the sensibility to light. The inequality is most frequently met with in those diseases which affect the body generally, and also are definitely localised to one side as well. When inequality is present in general disease, it is often due to some complaint.

In *neuroses* the inequality present is either a dilated or contracted pupil, and is not transient, but may last a year or more, and follows the changes of the causal disease. Very exceptionally is it due to disturbance of the third nerve. The third nerve may be inhibited by irritation of the fifth, *e.g.*, by carious teeth, therefore some such irritant should be looked for if a patient is found with unequal pupils and nothing to account for the inequality. The reflex inequality belongs to the functional variety, unilateral dilatation follows the phases of the causal condition, appearing and disappearing with the irritation of the peripheral or visceral, sensitive or sensory nerve which has provoked it.

In *hysterical* patients there may be complete amblyopia, and if there be no change in the fundus the pupil acts normally. In cases of hemi-anæsthesia, and capable of transference with it, the vision may be impaired and the acuity and field are reduced, and the colour fields also in their normal order, *i.e.*, first violet, then green, red, yellow and blue. The effect of electrical stimulation on the retina is lessened, but the action of the pupil is normal. Blindness may occur without any anæsthesia, when the pupil reacts and the fundus is normal. The lesion is usually sudden. One case has lasted for six years, sometimes improving and then relapsing, but without change in the action of the pupil or fundus.

Injuries to the head.

Concussion.—Macewen says that the pupils are widely dilated, and fixed, that this stage soon passes off, and that the first sign of recovering is contraction and mobility. The same in shock. During the stage of collapse the pupils are normal in size and respond to strong light. The response is often sluggish, not infrequently there is a tendency to slight contraction, and inequality in size is frequently seen. In a bad case of concussion, if the pupils react to light it is a good sign. If one pupil be fixed and the other react to light it indicates some brain or nerve injury and the prognosis is bad, the eye will be lost even if the patient recovers. Sometimes only one pupil is markedly dilated, and there are signs of irritation, these symptoms are probably due to a small hæmorrhage into the cortex on the same side. As whatever the condition of the circulation is, the functions of the brain are suspended, therefore the condition of the pupils might be expected to be the same as during sleep or anæsthesia. In a few cases of concussion a fixed and dilated pupil on both sides has been noticed for a time. Hutchinson thinks it is impossible to account for those cases in which dilatation on one side persists for some time, but these are rare without some injury to the brain. Mr. John Hilton recorded a case of injury to the head with complete blindness of one eye,

and a fixed and dilated pupil, and this condition was found to be due to a clot of blood in the fibrous sheath of the optic nerve about one inch from the eye.

With the onset of *inflammatory symptoms*, the pupils become strongly contracted, though the lesion may be at some distance from the corpus quadrigeminum superius. Page records in a case of a fall, in the right fronto-temporal region there was at first some coma, no paralysis and equal pupils. Seven and a half hours after patient developed a right hemiplegia and a dilated and immobile right pupil—the left being normal. There were no pressure symptoms and the dilated pupil was thought to be due to a small basal hæmorrhage, or to local injury to the third nerve. At the autopsy the anterior clinoid process was found to be fractured and the third nerve damaged, and there was a hæmorrhage into the left internal capsule. Mr. J. Hilton records a case of injury to neck with probably rupture of the transverse ligament, both pupils reacted to light and were dilated, the right being a little larger. On sitting the patient up the pupils contracted and were variable, the right the larger, and he became paralysed. Condition improved on lying down, showing some pressure on the medulla.

Compression.—Macewen says: *Slight compression* produces interruption of function of brain; the pupil is contracted and sluggish. *Severe compression.* – Function of brain suspended or abolished. Fixed and dilated pupil. Compression may be due to a depressed fracture. *Meningeal hæmorrhage.* (Mr. W. H. A. Jacobson.) While the condition of the pupils may be various there are three conditions which are most important:—

a. If the pupils are natural as regards reaction to light, the compression of the brain is probably a recoverable condition if trephining be immediately performed. Furthermore it is probably a case of compression only of the brain, without laceration or other injury.

b. If the pupils are insensitive and often at the same time dilated the compression is probably extreme, and while trephining is urgently called for, it is less probable that in these cases the brain will recover itself after removal of the clot. In general, as the mischief is continued and augmented, the pupils become dilated and immovable. If both pupils are equally dilated and fixed, this indicates a very large effusion.

c. If one pupil be found widely dilated and fixed, the other being natural or contracted in size, and if the dilatation be present on the side of the face, corresponding to the part of the head injured, in other words opposite to the paralysed side (if hemiplegia be present), it is a sign of the greatest importance. Mr. Hutchinson was the first to explain this condition of the pupil, and Mr. Jacobson proposes to call it the "Hutchinson Pupil." It is caused by the extension of the extravasated blood to the base, or to its being in the sphenoid fossa, and pressing on the trunk of the third nerve. One-sided dilatation, by itself, is not to be taken as diagnostic, but it is in conjunction with other evidence, *e.g.*, interval of consciousness, hemiplegia, coma, stertor and slow pulse, that this condition will be of value. It should also be remembered that it not only means middle meningeal hæmorrhage but a large clot, and if the case has been carefully watched, and this symptom has been absent at first, an extending clot. Also this symptom may come on suddenly, heralding, with a short interval, the onset of a fatal issue. Meningeal hæmorrhage may occur in new-born infants, following the use of forceps. In one case recorded, defective sight was found, but the fundus and pupil reactions were normal, showing the lesion to be cortical.

Great external hæmorrhage.—If the blood be withdrawn slowly so as not to cause syncope, when one seventh of total is withdrawn cerebral irritability is increased, and is accompanied by contracted pupil. When the amount lost equals one-fifth of the whole, the cerebral anæmia is so great as to seriously interfere with the functions of the brain, and pupils get dilated; if depletion pushed further they become dilated and fixed.

The pupil in anæsthesia.—Budin found that in administration of chloroform, during the excitation stage the pupil dilated, and when it was passed the pupil contracted again, though still sensitive to light, and would dilate on stimulation; when the stage of surgical anæsthesia was reached the pupils were immobile and contracted. The efforts of vomiting may produce dilatation of the pupils. He mentions nothing of the dilatation in the later stages. *Schiff*, criticising Budin, injected chloral and obtained complete anæsthesia with a punctiform pupil. He then administered chloroform in a bag and found that the pupil dilated; on withdrawing the chloroform the pupil contracted; on again administering it pupil dilated. His experiments were upset by several French investigators who found that after injecting chloral they could reproduce the dilatation and contraction of the pupil described by him by merely shutting or opening the windpipe, and that, if the chloroform be administered in the open air, there is no change in the pupil. Experiments of Bubin, Coyne, and others, show that in *asphyxia* the pupil is first moderately dilated; then becomes widely dilated and fixed in the later stages. Schiff's results were, therefore, due to asphyxia through administering the chloroform in a bag.

During the administration of chloroform, in the first stage the pupils are not affected and are normal in their reactions. In the second stage, the pupils are generally mobile and more or less dilated. They react sluggishly or not at all to light, and as the third stage approaches they become smaller and more fixed. In the third stage the pupils are moderately contracted, 2–3 m.m. in diameter. They are smaller than the average "ether pupil" ($3\frac{1}{2}$–$4\frac{1}{2}$ m.m.) Both respond in a similar manner to an increase or decrease in the quantity of the anæsthetic given, and are similarly affected by light and other stimuli. Occasionally, in chloroform anæsthesia the pupil remains widely dilated throughout; this is often so in operations on the neck, such as the removal of deeply-seated glands, therefore in these operations the pupil must not be relied upon as a guide. A very small pupil generally indicates light anæsthesia,

dilated pupils usually mean that the anæsthesia is profound, or more probably the dilatation is of reflex origin and is associated with a light anæsthesia. The pupil is not to be taken as a guide till after the operation has been in progress some little time, and until the administrator has satisfied himself that it reacts properly to more or less of the anæsthetic. The lid reflex is of less value than the pupil, for often when it is absent, the patient is yet liable to swallow, cough, or vomit. Whilst on the other hand cases occur with a good lid reflex and yet with other signs of a proper degree of anæsthesia. The pupil is most useful as a guide when the other signs are equivocal, *e.g.*, when the breathing is shallow and the lid reflex absent and when from the nature of the operation, the breathing is deprived of its usual characteristics. A dilated pupil is a good guide as an indication of returning consciousness, but it must be made very certain that the patient is recovering and not actually becoming more deeply anæsthetised. On administering a fresh dose of chloroform to a patient with the dilated pupil of recovery, the effect is not immediate, and does not appear till after five or six inspirations, when the pupil contracts. This delayed action of chloroform is especially marked in children and the danger can be readily seen, for if an increased dose be given to a patient with the dilated pupils of danger, the patient may receive a fatal dose before sufficient time has elapsed to observe the effects of the dose. Generally a dilated pupil with a conjunctival reflex calls for more chloroform. If dilated and no conjunctival reflex it calls for withdrawal of the anæsthetic till the pupil is smaller.

The pupil under ether.—During the first stage the pupils are very large and very mobile; during the second stage the pupils are still mobile and usually more or less dilated; during the third stage the pupils differ from the chloroform condition in some respects, usually being of moderate size or slightly dilated, from 3½–4½ m.m., and they are *active to light*. If deep anæsthesia is required, the ether may have to be pushed till the pupil is considerably dilated, 5–5½ m.m.; as the third stage becomes fully established the pupils lose their mobility and gradually settle down to a particular size for a particular case. As with chloroform, the pupil is not to be relied upon as a guide till the anæsthesia is fully established. Then notice whether any reflex dilatation takes place when the operation is begun; if the patient be deeply under, no dilatation or but very little will result. Should such occur it will usually gradually subside, but may persist. A state of pupil should be established so that if less ether be given the pupil gets smaller, and if more be given it gets larger. For instance, if a pupil of 4 m.m. comes down to 2 or 2½ m.m. the patient will usually begin to swallow, strain, or cough. The reactions of the pupil to more or less of the anæsthetic may be complicated by the tendency to reflex dilatation as the result of the operation; this will be more marked in light anæsthesia, and may be checked by more of the anæsthetic. Neurotic and anæmic subjects as well as children often exhibit a great susceptibility to reflex dilatation of the pupil. In old people, and those with a less highly developed reflex the pupil is less likely to vary and is usually smaller. Operations in the neighbourhood of the sympathetic are liable to produce dilatation; in this case the pupil gets smaller if more anæsthetic be given and larger with less. Any marked deprivation of oxygen, *i.e.*, the patient getting blue, will tend to increase the size of the pupil.

The pupil with A.C.E. is generally about the same size as in chloroform narcosis, or perhaps slightly larger. A dilated pupil with a lid reflex calls for more anæsthetic; if without a lid reflex the administration should be withheld. A very small pupil with a tendency to rigidity and very quiet breathing points to a light anæsthesia.

With nitrous oxide gas alone, the pupils usually begin to dilate in the second stage, and in the third stage are usually dilated; in the fourth stage, or stage of overdose, they are widely dilated, the eyes are upturned and the patient is of a livid hue and respiration stops. The heart, unless diseased, may go on for some time.

With gas and oxygen the pupils are usually of moderate size, and wide dilatation is rare. They have been observed at contract and dilate in response to a greater or less percentage of oxygen.

The pupil in eye disease.—With simple optic atrophy we get the Argyle-Robertson pupil.

Iritis.—In iritis the pupil is greatly contracted; the exudation lines all the anterior chamber and lines the iris, and stretches from it over the anterior capsule of the lens in the area of the pupil, which consequently appears grey, and if this exudation become organised, a membrane is formed which occludes the pupil. The exudation poured out into the posterior chamber shows itself by producing adhesions between the posterior surface of the iris and the anterior capsule of the lens. These form when the iritis is at its height, and, therefore, when the pupil is contracted, so that on recovery, when the pupil tends to resume its normal position, it can only do so where there are no adhesions, consequently the pupil is irregular, and the irregularity shows still more when the pupil is dilated with atropine. If the adhesions are broken down by atropine, a circle of little dots of pigmented epithelium is left where the adhesions were, and these always remain as black dots in the pupil, and are evidence of previous iritis. They are arranged in a circle, which is of smaller size than the normal pupil. Syphilitic iritis may occur either in the secondary stage or may be hereditary. The diagnostic points are the broad synechiæ and small collections of lymph on the margin. In cases of serous iritis, such as are caused by a blow, Nettleship says the pupil may be dilated.

Glaucoma.—In the prodromal stage the pupil is more dilated than normal and reacts sluggishly. In the second stage, which starts by an acute attack, the pupils are dilated, hence if a drop of atropine be put into the eye during the prodromal stage, it may start an acute attack. Other symptoms are pain, diminution of

the field, and increase of tension. The iris is discoloured, the pupil dilated, and often oval and eccentrically placed. The reaction of the iris is either diminished or abolished, and a greyish-green reflex is obtained from the pupil. In the third stage, called glaucoma absolutum, the iris is reduced to a narrow grey marginal tract, which in places is almost concealed by the limbus, and which at its pupillary border is encircled by a broad black band — the pigmented epithelium. The dilated and rigid pupil is greenish or of a dirty grey.

Anterior synechiæ, follow prolapse of the iris through a wound of the cornea. If the synechiæ is situated peripherally the pupil is drawn towards the adhesion, and has the shape of a pear with a sharp end towards the adhesion. If the perforation has been nearer the centre the distortion of the pupil is slight or absent. If the perforation be so large that the whole of the pupillary margin is involved and becomes attached to the cornea in healing the pupil gets occluded by the scar.

Congenital defects in the pupil.

Persistent pupillary membrane may be present in several forms. These are:—

1. Fibres stretching across the pupil and forming a network in front of the pupil.
2. Fibres running tangentially.
3. All the toothed projections of the circulus iridis minor running in and projecting beyond the margin.
4. One or more free floating fibres.
5. A loop formed by two fibres.
6. One or two fibres from the circulus iridis minor to the anterior capsule running from the front of the iris over the pupillary margin to reach the capsule. These differ from synechiæ in that they are not attached to the pupillary margin, and when the pupil is dilated (naturally or by drugs) the pupil does not alter its shape. The fibres being stretched and thinned, dilatation is not limited by them.
7. Fibres to the posterior surface of the cornea.

Irideremia. — The iris may be entirely wanting or consist of only a small residual portion.

Coloboma, due to failure in closure of the gap in the secondary ocular vesicle, through which the mesoblast enters the eyeball. Usually downwards with a deviation to the right or left. The pupil is pear-shaped. The difference from an iridectomy is that the pupillary margin and the sphincter iridis are continued down to the apex of the coloboma. It has been recorded in all directions.

Other congenital abnormalities of the pupil:—

1. Altered in position (corectopia) usually slightly eccentric; extreme cases are associated with ectopia lentis, the direction commonly upwards and outwards.
2. Abnormally small (microcoria)—usually the result of fœtal iritis.
3. Abnormal shape (discoria) due to posterior synechiæ, persistent remains of the pupillary membrane.
4. Multiple pupils (polycoria).

a. Normal pupil divided by a bridge formed by some persistent remains of the pupillary membrane.

b. Coloboma with a bridge.

c. Numerous openings in the pupil with a normal central pupil.

d. In a case recorded by Mr. Higgens of congenital multiple pupils there were four pupils on the right side, three being little more than slits, and two on the left side, one being only a slit, all reaching to the periphery. There was no central pupil. The fundus could be seen through all. There was no evidence of iritis or hereditary syphilis. The patient could read J i at six inches.

Prizes.

The undermentioned prizes have been awarded as follows:—

Senior Prizes for General Proficiency.—Mr. G. S. Simpson, a prize of £20; Mr. E. Cohen, a certificate.

Junior Prizes for General Proficiency.—Mr. P. R. Bolus, *first prize of £20*; Mr. E. H. B. Milsom and Mr. N. I. Spriggs, equal £12 10s. each; Mr. K. Black, a certificate; Mr. R. Larkin, a certificate; Mr A. M. Webber, a certificate.

Wooldridge Memorial Prize in Physiology.—Mr. P. R. Bolus, a prize of £10; Mr. N. I. Spriggs, a certificate; Mr. E. H. B. Milsom, a certificate.

Guy's Hospital,
April 10th, 1900.

Guy's Hospital Dental School.

TRAVELLING SCHOLARSHIP.

A Travelling Scholarship of the value of £100 has been founded.

The first award will be made in June, 1900.

The Scholarship is open to Licentiates of Dental Surgery of the Royal College of Surgeons of England who have been educated at Guy's Hospital Dental School.

Names of applicants for the Scholarship must be sent to the Dean of Guy's Hospital, on or before June 1st, 1900, from whom also further particulars may be obtained.

Guy's Hospital, March, 1900.

In our notice of Chloretone, in our last issue, we omitted to state that it is prepared by Messrs. Parke, Davis & Co., of North Audley Street, W.

Death.

STUART.—On the 19th of March at Fyzabad, India, Frances Helen, the dearly-loved wife of Major S. O. Stuart, R.A.M.C., 30, Woolwich Common, aged 23.

Ed.—S. H.

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Calendar of Coming Events.

April, 1900.

Sat. 28.—Messrs. Jacobson and Fripp's take-in; Drs., F. Curtis and L. E. Stamm; Cl., E. W. Goble.

May.

Tues. 1.—Summer Session begins.
Reports for Bredin Prize for Clinical Study to be sent to the Dean, at the Medical School Office, by this date.

Wed. 2.—9 a.m. Mr. Pakes lectures on Bacteriology (Dental).
1.30 p.m. Clinical Lecture by Dr. Fawcett.

Thurs. 3.—Messrs. Howse and Symonds' take-in; Drs., A. C. Nash and J. F. Douse; Cl., H. McD. Parrott.

Fri. 4.—1.15 p.m. Clinical Lecture by Mr. Symonds.
9 a.m. Mr. Pakes lectures on Bacteriology (Dental).
2 p.m. Bacteriological Classes.
4 p.m. Lecture (Mr. Pakes).

Sat. 5.—G.H.L.T.C. I and II. Trial Matches, away.

Mon. 7.—Final M.B. Lond. Exam. begins.
Practical Dental Exams. for Prizes begin.
2 p.m. Bacteriological Classes.
4 p.m. Lecture (Mr. Pakes).

Tues. 8.—2 p.m. Bacteriological Classes.
4 p.m. Lecture (Mr. Pakes).

Wed. 9.—1.30 p.m. Clinical Lecture by Dr. Shaw.

Thurs. 10—Messrs. Lucas and Lane's take-in; Drs., G. S. C. Hayes and H. J. Gater; Cl., C. B. Thomson.
Probable date of Primary Fellowship Exam.
Cambridge First and Second M.B. Exam. Schedules to be brought to the Medical School Office for signature.

Fri. 11.—1.15 p.m. Clinical Lecture by Mr. Symonds.
Probable date of Exam. for L.D.S. Eng.
2 p.m. Bacteriological Classes.
4 p.m. Lecture (Mr. Pakes).

Sat. 12.—G.H.L.T.C. I. South Croydon, away.

Guy's Hospital Gazette,

APRIL 28, 1900.

Intra-thoracic Pressure.

CLINICAL LECTURE BY DR. TAYLOR.

February 17th, 1900.

Gentlemen,—The case I have to speak about to-day is a man, aged 36, who was admitted for shortness of breath, hæmoptysis and pyrexia. His family history is good. Two years ago he had an attack of pleurisy, and was laid up at home for a few weeks. He was quite well for eighteen months after this, when he had another attack on the left side. He was again treated at home, but did not recover from this second attack as he had from the first, but frequently brought up small quantities of blood-stained phlegm. He attended Dr. Washbourn's out-patients' for six weeks, and then thought he had entirely recovered. At the end of last November, however, he had pain in the left side, and again brought up small quantities of blood. He felt very weak, and gave up his work. Shortly before admission he became breathless, and about the same time his voice became husky. When admitted on January 26th, he was "a well-nourished man, of good complexion, in no apparent pain, but rather short of breath. There is considerably more movement on the right side of the chest than on the left. The intercostal spaces on the left side are obliterated, while those on the right are clearly indicated. The left chest is dull all over, and tactile vocal fremitus is diminished over the apex, and absent over the rest. The breath-sounds are diminished over the whole of the left chest, and expiration is slightly prolonged. The voice sounds are diminished, and ægophony is heard near the lower angle of the left scapula. The breathing over the right of the chest is compensatory." The impulse of the heart "seems to be situated under the lower end of the sternum. The cardiac dulness extends one inch to the right of the sternum, over the fourth, fifth and sixth ribs. There is a harsh systolic bruit heard in the aortic and pulmonary areas, and along the right border of the sternum. There is trachael tugging. There is no inequality of the pupils or pulse. A blood-count shows: red corpuscles, 4,250,000; white corpuscles, 9,800; hæmoglobin, 60 per cent. The urine is normal."

On the 29th of January "the patient's left chest was explored, and clear fluid was drawn

off. On February 1st the chest was aspirated, and thirty-two ounces of clear fluid were withdrawn. The fluid contained staphylococci, probably derived from the skin. The sputum several times contained blood." On February 5th it is noted that "the patient weighed 132 lbs.; he stated before that his weight was 150 lbs." so that he now appeared to have lost 18 lbs. On February 6th, five days after the tapping, "there is still dulness and deficient breath-sounds and voice-sounds over the lower part of the left chest. No hæmoptysis. A systolic bruit is well marked on either side of the spine behind." On the 9th: "There is dulness all over the left side of the chest and deficient entry of air, and at the apex there is some bronchial breathing. There are no râles or rhonchi. The voice-sounds are diminished on the left side, and the patient's voice is very husky." On the 12th: "His weight is 139 lbs." a gain of 7 lbs. during the week. There is still deficient resonance and air-entry on the left side. The patient's voice has improved, the tracheal tugging is scarcely perceptible. An examination with the laryngoscope shows that the left vocal cord is quite motionless. There is no œdema of the chest wall, or distension of superficial veins."

I was examining him yesterday, February 16th, three weeks after admission, and he had still dulness over the whole of the left side, back and front, deficient entry of air over the same area, and the breath-sounds were slightly bronchial at the apex. The cardiac dulness reached to the right border of the sternum, but was not well pronounced beyond that.

The vocal cord remained paralysed. The patient was also expectorating, and has been expectorating for some days a large quantity of purulent sputum, almost pure pus.

There is another important and interesting fact, the temperature is distinctly febrile. The chart shows that every day since the patient's admission the temperature has been up in the evening or the latter part of the day to 101°; it has frequently risen slightly above 101°, sometimes over 102°, and yesterday it was up to 104°, whereas the morning temperature is very frequently below 98°. So that we have an oscillating temperature that varies from the normal line some three, four, and yesterday, very nearly six degrees. The removal of the fluid on February 1st did not make any material difference in the progress of the temperature.

Let us take the main features of this case. We have, first of all, pleuritic effusion. I am not going into the diagnosis of pleuritic effusion; that was proved to exist by the exploration, and by the subsequent removal of a certain amount of fluid. Then it is found that the patient has paralysis of the left vocal cord; that he has a murmur in connection with the heart or vessels; that he has cough and expectoration of purulent sputum, or sputum which is now purulent, and which has at different times contained blood. You will notice that his illness commenced two years ago, but that for a part of that time he has been comparatively well, at any rate he has improved and recovered and then again got worse. How far, therefore, the first illness is connected with his present condition is a difficulty indeed that we have to surmount.

Now, what is the matter with the patient? To what are we to ascribe these lesions that we find? It will be best to take some of these symptoms in detail and see what bearing they have upon the possible cause, and I will take *effusion into the pleural cavity* first.

We may ask this question, Is it a case of pleurisy or of hydrothorax? Is the fluid the result of inflammation of the pleural sac? or is it a dropsical condition of the pleural sac? There is no doubt, I suppose, that the greater number of cases in which we have fluid in the pleural cavity are inflammatory in their nature, and the question is, Do we often enough ask ourselves whether they are inflammatory, or do we not assume it with too little consideration? What I have just said has an important bearing in this case. It would be very satisfactory if we could know that we were dealing either with pleurisy or with hydrothorax. Is there any difference between the fluid of pleurisy and of hydrothorax? Fluid in the chest which is the result of dropsy or passive effusion is of a lower specific gravity than fluid which is the result of inflammation. The serous fluids which are the result of inflammation have a specific gravity of 1018 to 1024; in hydrothorax the specific gravity is much lower, it may be 1012, or even 1006. With regard to chemical examination of these fluids there is a diminution of the various solids in the case of hydrothorax which corresponds, of course, to a diminution in the specific gravity. Unfortunately we have no information on the specific gravity of the fluid withdrawn in this case.

But, from the history we hear that the patient had pain in the side. At any rate, a long time ago, in his original illness, there was pain in the side, and it is stated that he had an attack of pleurisy. Then at the end of last November he had pain in the left side, and brought up small quantities of blood. So that

we have his statement that he had pleurisy, and his statement later that he had pain in the left side two years ago; all which went in the direction of making out that he was suffering from pleurisy and not hydrothorax. The bearing of these observations is this, that an effusion which is passive (hydrothorax) and not inflammatory is indicative of a retarded venous circulation in the chest, and may be due either to heart disease, or to some local intrathoracic pressure—such as results from a new growth, or from aneurysm. If, on the other hand, it is a pleuritic or inflammatory effusion, it may have to be accounted for in some other way.

Now, we will take another and a very important point, and that is the *laryngeal paralysis*, The patient has one cord paralysed, as I have already said. The left vocal cord lies constantly almost in the middle line and is motionless, whereas the right vocal cord moves more or less freely in phonation and respiration. He breathes without stridor and without noise, and he can approximate the right cord to the left so as to speak on phonate, though his voice is rather husky, that is to say, the vibration of the cords is not absolutely perfect.

This position of affairs is what is commonly known as abductor paralysis, that is, paralysis of the *abductor* of the glottis (or of the vocal cord). It is distinguished from *adductor* paralysis, or paralysis of the adductor of the glottis (or of the vocal cord).

Does that help us at all? What does this paralysis of the left abductor mean? Are we to think over the muscles of the larynx and vocal cords and find out which muscle is paralysed, or which nerve is pressed upon in order to produce this paralysis? What are the abductors of the vocal cords? The abductor of this vocal cord is the left posterior-crico-arytenoid muscle, and the abductor of the right vocal cord is the right posterior-crico-arytenoid muscle. Now the nerve which innervates the posterior-crico-arytenoid muscle is the recurrent laryngeal nerve of the same side. But we also know that the recurrent laryngeal nerve innervates the adductor muscles of its own side as well, and therefore we want to know why if the recurrent laryngeal nerve is affected the abductor should be paralysed and the adductor should not.

This subject is rather a long one, and one which I do not think I can fully enter upon at the present time. But experience has long shown this—that if either recurrent laryngeal nerve gets pressed upon or gets diseased, as, for instance, by a tumour, or growth, or aneurysm, the abductor muscle is paralysed first; and the adductor muscles, supposing the cause persists, are paralysed much later. Now for a long time, at any rate, it was not obvious that there was any anatomical reason why this should be, and one might say that the fact alone was all we had to be content with, with the additional hypothesis or formula that there was a tendency on the part of the abductor fibres to suffer when any injury was offered to the trunk nerve *in toto*. And so, when you see a paralysed abductor you are not to infer that there is any special selection of one part or other of the nerve, or one branch, or some particular fibre, but that it is simply an expression of the fact that a certain damage is being done to the trunk nerve, and that if that damage goes on, in time other muscles, the adductors, will be paralysed as well. That is the position we are in with regard to this present case. This abductor paralysis is simply an indication to us that the recurrent laryngeal nerve, or the vagus nerve, or the vagus-nucleus possibly, is being involved. Here, of course, we should say the recurrent nerve, because all the symptoms point to the chest and not to the neck, or to the medulla oblongata.

I ought further to say that it is generally admitted that the paralysis is not simply paralysis of the abductor, but that there is in addition what is called a paralytic contraction of the adductors afterwards; that is, it began with abductor paralysis, but the position of the vocal cord in the middle line is determined by the subsequent antagonistic contraction of the adductor. But the essential fact, of course, in relation to the origin of the disease is the fact that the abductor is paralysed. And you must understand that there are cases in which you get double paralysis of the abductors; and that pressure on the recurrent laryngeal nerve or nerves from any cause whatever may bring about this change. If the pressure is unilateral the result will be unilateral, and if bilateral the result will be bilateral.

Now let us take another symptom, viz.:—*Expectoration*.—You may say, "Expectoration is such a common event in various thoracic diseases that perhaps it can very well be left out of account in this case." But this expectoration presents two features: one is that it is purulent, and the other that it has been from time to time bloody. I have not got a very full description of the bloody sputum; I have not seen it myself, but I have been told that it was like prune juice, that is to say, altered blood, blood that is not perfectly red or quite black,

but of a purplish red colour, having been altered probably since its extravasation by existing a certain time in the bronchial tubes. But this purulent sputum, of course, is a very common thing; you get it whenever there is sufficiently intense inflammation of the bronchial tubes.

Taking first the purulent sputum, it must have come either from the bronchial tubes or from cavities. There is no evidence that it is tubercular; no tubercle-bacilli have been found in the sputum, and therefore it probably does not come from phthisical cavities. Then, if this purulent sputum comes from the bronchial tubes, we must admit that many patients suffer from bronchitis which may be entirely unconnected with subsequent serious symptoms. But I do not think that is the position in this case. From the history we must regard the purulent sputum as a point worthy of careful consideration in relation to the possible cause of this patient's illness.

How can intra-thoracic pressure bring about purulent sputum? There is one way which must be always remembered in cases of this kind, and that is, if you have partial compression of a large bronchial tube you will get, as a result of that, dilatation of the tubes behind; and when the tubes behind are dilated they tend to secrete a purulent material, and to produce an expectoration such as we have in the present case. That is to say, compression of a bronchus produces local bronchiectasis, and bronchiectasis results in purulent sputum. It is true that the purulent sputum of bronchiectasis is sometimes offensive from retention and decomposition, and presents special characteristics which are not present here. But these changes are sufficiently constant to enable us to deny the possibility of bronchiectasis being the cause of the sputum in this case.

Now with regard to blood in the sputum. Of course blood will result from any intense inflammatory process or congestive process involving the vascular mucous membrane. You may have, as you know, blood as the result of pneumonia, whether broncho-pneumonia or lobar (croupous) pneumonia; or it may be due to tubercular disease and cancerous disease involving the bronchi; you might have it conceivably from an aneurysm pressing upon a portion of the lung, interfering with its circulation in such a way as to lead to local congestion, and hence extravasation of blood.

So far as this purulent sputum and the hæmoptysis are concerned, if they are not to be explained by a tubercular lesion, then they are probably the result of some intra-thoracic pressure in the neighbourhood of the root of the lung and the hæmoptysis may conceivably be directly from a cancer of the bronchus.

And then we have the *murmur* or the *murmurs*. They, I confess, are rather difficult to deal with. We know very well that murmurs are very apt to be produced under circumstances other than a mere occurrence of mitral and aortic valvular lesions. Murmurs are sometimes produced by displacement of the heart, as for instance, by a pleuritic effusion; sometimes they are produced by pressure on the pulmonary artery and on the aorta by an aneurysm. So that there are many other causes of murmur besides the straightforward, ordinary, common mitral disease or aortic disease. This murmur is heard over the pulmonary and aortic regions, and further, while it is only faintly heard over the mitral area, it is heard on both sides behind. A mitral murmur is frequently heard behind, but this cannot be primarily mitral. An aortic murmur is sometimes also heard behind. But it is not very common for an aortic systolic murmur to be heard behind; aortic diastolic murmurs are more often heard behind than aortic systolic murmurs. Then considering that there are points about this case which are suggestive of aneurysm, it may be that the murmur is, at any rate, partly due to that disorder. A tumour, also, might conceivably be pressing upon the heart or displacing the heart, or pressing upon one or other vessel in such a way as to produce a murmur such as we have here.

I think, now, I have succeeded in showing you that some form of intra-thoracic pressure may really be the cause of these various symptoms, that is, if we assume that all these symptoms and conditions are due to one disease, and that is an important question over which I may just spend a few minutes. As a rule, our struggles in diagnosis are directed to the detection of one single lesion which can explain everything. That is a right idea and a proper principle. It is not a satisfactory thing to describe a case, for instance, as one of pleuritic effusion, hæmoptysis, bronchitis, paralysis of the left vocal cord, and fever. That would do for the public; they would be satisfied that the patient had got all these various complaints, and it might be a gratification to them that their relative was succumbing to a "complication of diseases." But our effort is always to find, if possible, one single lesion that shall explain everything, because, on the whole, the majority of people do only suffer from one severe disease at the same time; and because we know that a single lesion will disturb the functions in many

parts of the body, from the close physiological interaction of its different systems. But, on the other hand, supposing you should, struggling over this diagnosis, find no satisfactory solution in this direction, you must remember it is possible that the patient may have two primary conditions of disease which have no connection with one another, that is to say, neither one is the cause of the other. If you never remember that, you may occasionally find yourself in a dilemma and fail to get a right solution of the case.

Let us now return to this idea of intra-thoracic pressure, of something growing or forming in the centre of the chest and pressing an important part, and see what things are possible. I have mentioned some of the possible things already incidentally in connection with the results. Two things especially are often contrasted as causes of intra-thoracic pressure, namely, (1) aneurysm of the aorta, which may be aneurysm of some portion of the arch of the aorta, or of the thoracic descending aorta; and (2) mediastinal growths, of which we are most familiar with the carcinomatous, sarcomatous, and lymphadenomatous tumours arising in connection with the glands situated in the mediastinal space. It will not be possible for me to go *seriatim* through all the symptoms which are indicative of such lesions and contrast them in detail, but I may take some of the more important illustrated in this case.

Let us take, first of all, the paralysed laryngeal nerve. You will remember what course the recurrent laryngeal nerve takes. The vagus nerve comes down in front of the arch of the aorta, and the recurrent larnygeal nerve is given off just about the upper part of the arch, turns round under it and runs upwards along the side of the trachea, between it and the œsophagus. We have no evidence that the patient has any mischief in the neck. It is pretty clear that the lesion is in the chest, and therefore if this laryngeal nerve is at fault the lesion must be situated between the upper part of the sternum and the lower part of the arch of the aorta. You see that locates the disease very closely, to a space of a few cubic inches.

It is not very uncommon for an aneurysm to arise in that situation. An aneurysm may arise from that concave portion of the arch, and if it arises there or from the front of the arch it will press on the recurrent laryngeal nerve and cause the kind of paralysis we have in this case. At the same time such an aneurysm is in a position to interfere with the bronchus, and also with the pulmonary artery. Now the bronchus is not infrequently interfered with in these circumstances. The bronchus may be compressed, and if it is compressed you may get deficient breath-sounds over the chest. We have no means in this case of ascertaining whether that bronchus is compressed or not, so far, because any diminution of breath-sounds over the chest that might result from such compression has actually been produced in this case by the fluid which is outside the lung. But experience in pathology shows that aneurysm may arise in that situation. And you know it may arise in a situation a little more forward than that, and then it will compress this recurrent laryngeal nerve without compressing the bronchus. Or an aneurysm may arise from the back of the arch of the aorta and compress the recurrent laryngeal nerve, and also press backwards and interfere with other important parts. So that an aneurysm is a possible cause of this patient's troubles.

Then we have fluid in the chest. How can we account for that? I think there is no doubt that an aneurysm is not a very frequent cause of pleuritic effusion. An aneurysm, of course, may press upon some of the veins; it may press on the bronchial veins and cause their circulation to be interfered with and the blood in them to be stagnated, and so lead to an effusion of serum into the pleural cavity, a condition which is known as hydrothorax. An aneurysm situated there may press backwards upon the costal veins and by interfering with them lead to dropsy. And I do not think we can exclude aneurysm from consideration, supposing this is hydrothorax, though, on the whole, it is more likely to be an inflammatory effusion. Pleurisy is an exceedingly common complication of any lesion of the chest. If a tumour, or cancer, or sarcoma, or heart-disease interfere with the circulation in any kind of way, there is a tendency towards the production of pleurisy; whatever micro-organisms may be available or accessible seem to have a greater chance of developing that tendency when these local disturbances of the circulation have occurred.

I have already shown the possible relation of aneurysm to the expectoration. An aneurysm may be causing some diminution of the calibre of the patient's left bronchus, thus bringing about a local bronchiectasis productive of the pus which we have here. And if that pressure is taking place, there may be sufficient interference with the local circulation to account for hæmoptysis. Hæmoptysis occurs in aneurysm in another way, but that is very rare; I mean that

an aneurysm which is pressing on a bronchus may some day open into that bronchus and produce fatal hæmoptysis. But before that, some days or weeks, there may be simple oozing of blood through the laminated deposit in the aneurysmal sac, this finding its way to the surface of the trachea or bronchus and being expectorated some time before the actual fatal rupture. But that is not a very common event, and considering the duration over which this patient has had hæmoptysis, it is very unlikely to be the case with him.

Then as to the murmur. A murmur behind is sometimes heard in the case of aneurysm which grows into the spine and erodes the vertebræ. And it is possible that in this case an aneurysm may be present which will interfere with the conditions of the heart and vessels in front and produce the murmur which we hear over the aorta.

There have been other symptoms of interest and importance. It appears that when the patient came in there was "tracheal tugging." The best way to examine for this symptom is for the patient to be placed in a chair, and then the physician standing behind him places one or two fingers of each hand under the cricoid cartilage, and pulls it, and therefore the trachea, in an upward direction. In cases where tracheal tugging is present there is a pulsatile movement communicated to the fingers due to the beat of the aneurysm or of the aorta, and though it may be allowed that a certain amount of pulsation may be felt in some healthy people, such a pulsatile movement is communicated to the fingers in a way very much greater when an aneurysm is present, which presses upon the bronchus. There is a difficulty about this case, namely, that the tracheal tugging is less than it was; it is not nearly so plain as when the patient first came in, and for an aneurysm to diminish so much as that in a short time is perhaps rather an unusual event. The presence of this phenomenon has been regarded as certainly diagnostic of an aneurysm of the concavity of the arch, but aneurysms of other parts occasionally cause it. In No. 10, Clinical Ward, a few years ago, there was a case of aneurysm of the innominate artery. It formed a sac which crossed towards the middle line, and was adherent to the trachea, so that when the trachea was pulled up the movements in that aneurysm were communicated to the trachea in a way which did not come out when the trachea was not pulled up.

You know that an aneurysm makes the pulse unequal and the pupils unequal. It is expressly stated that they were not affected in this case. An unequal pulse is nearly always due to obstruction of one of the blood-vessels, as, for instance, the innominate or the subclavian. With regard to unequal pupils, it is a matter of localisation. An aneurysm may exist in such a position as to press on the sympathetic, and then you may get contraction on the same side as the sympathetic that is involved.

Does the history help us? The points bearing on the case are the presence or absence of syphilis, and the duration of the illness. Syphilis would be in favour of aneurysm, but so far as we can ascertain he has never suffered from it. The duration from the occurrence of the first bleeding is two years, but there has been an interval of health, and the more immediate illness that we are concerned with, is only of three months' duration. Aneurysm may have a duration of some years; the life of an intra-thoracic growth is generally measured by months only.

The important alternative to aneurysm as a cause of this intra-thoracic pressure is of course a mediastinal or pulmonary new-growth, and we may as briefly as possible consider its relation to the symptoms and lesions we have described. Cancer of the lung frequently causes pleural effusion, much more frequently, in proportion to the cases of its occurrence, than aneurysm.

With regard to compression of the recurrent laryngeal nerve, that is a matter simply of situation. The recurrent laryngeal nerve is not unfrequently compressed by growths. Cancer of the œsophagus, for instance, at the root of the neck, may produce double paralysis of the vocal cords in consequence of invading on either side the recurrent laryngeal nerve. Therefore, so far as this case is concerned, the presence of growth is quite possible.

If the purulent expectoration is due to a bronchiectasis, as I suggest it may be, this is quite as likely to arise from the presence of a mediastinal or bronchial new growth as from aneurysm. One might quote instances of this, but time will not allow.

Then the bloody sputum is, of course, of great interest because malignant disease undoubtedly does lead to bleeding. Some cases of cancer of the lung have been primarily cancer of the bronchus, and in cancer of the bronchus the liability to hæmorrhage is considerable. Very interesting cases of primary cancer of the bronchial mucous membrane have occurred, in which hæmoptysis has been a fatal symptom.

I have already suggested that the murmur is not valvular in origin, but a murmur due to pressure on a vessel by whatever obstructing

mass, whether aneurysm or other growths, may be present. And as a new growth may press on a vessel and so a murmur arise, we must admit that again in the occurrence of murmur we have little to help us to a final decision.

But this leads me to tell you of an important point of difference which you should always remember in relation to the diagnosis between aneurysm and malignant disease. Sarcomas, carcinomas, and epitheliomas, as a rule, respect arteries, and do not invade them at all. You will sometimes find arteries tunnelling right through a mass of cancer, and yet absolutely unaffected. It is true that sometimes cancer will grow into the aorta or the œsophagus and produce fatal hæmorrhage, but that is comparatively rare. Whereas, on the other hand, aneurysm is a disease which involves arteries primarily, and is therefore likely to interfere with the arterial circulation. An obstruction which one gets in the innominate, or the subclavian, is conceivably easy enough because of the anatomical relations of an aneurysm, and because of the deposition of clotted fibrin in its cavity. On the other hand, intra-thoracic growths are most likely to invade the veins and obstruct them, or cause thrombosis in them. Of this so far we have no evidence in the present case unless the pleural effusion, of doubtfully passive character, be so regarded. We have not hitherto got the œdema of the head and neck or of the upper extremities, or the enlargement of the superficial veins of the chest and abdomen, which are the unerring signs of an obstruction in the great veins, the venæ cavæ, near their entrance into the auricle.

Is there a third possibility?

Can, after all, the mischief be tubercular? We have not found the tubercle-bacillus, and that fact is against tubercular disease. You remember, however, that the patient has hæmoptysis, expectoration of pus, wasting, pleuritic effusion, and a paralysed recurrent laryngeal nerve which might very well be pressed upon by tubercular caseous glands. This is well known to occur occasionally in children. But the sequence of events is not that of phthisis, nor the appearance of the man that of one dying of phthisis; and though he has some fever, of which I have said little, I think no one of any experience would be willing to regard him as a case of this disease.

There remain two symptoms for further consideration. One is pain. You may be surprised that pain has not had to be mentioned before. It is commonly looked upon as a frequent, if not constant, accompaniment of both aneurysm and new-growths; and yet with the exception of the pain in the side, which appeared to be associated with his pleural effusion, the patient does not seem to have suffered at all from this symptom. No doubt the pain of aneurysm or growth depends very much on the situation, the size and rapidity of growth, and the extent to which different tissues are stretched or pressed upon. Aneurysms at the root of the lung would cause little pain; growths in the same situation, or growths commencing in the bronchus, may be for a long time, or throughout, painless. This fact does not militate against either of these sources of intra-thoracic pressure.

The other symptom is fever. The patient's temperature has oscillated from a low level in the morning to a high level in the evening with great uniformity. This is not readily explained by an aneurysm, and it is not generally regarded as characteristic of new growths. It is probably the result of one of the secondary lesions—that is either of the pleural effusion, if that is indeed inflammatory—though it must be remarked that the temperature was but little affected by the removal of the fluid—or by the purulent secretion from the dilated bronchi with its partial retention and absorption. This, then, is not incompatible with the diagnosis of aneurysm or of new growth, but, on the whole, is more in favour of the latter.

Finally, I must allow that the diagnosis as between aneurysm and new growth is in this case very difficult; and that the points in favour of one or the other are very evenly balanced; but that one of these forms of intra-thoracic pressure is certainly present.

The duration of the symptoms, the existence of a murmur, the tracheal tugging and the laryngeal paralysis are rather in favour of an aneurysm. The pleural effusion, the loss of flesh, the fever, and the expectoration are rather in favour of new growth. Aneurysm is no doubt of more common occurrence than new growth; and, on the whole, I incline rather to this view of the case, while waiting for further developments which may render a diagnosis certain.

Note.—The patient whose case is above described died on April 4th. On March 9th the left chest was again aspirated and nine ounces of blood-stained serum were withdrawn. Subsequently the dyspnœa increased, the parietes of the abdomen and the lower part of the chest became œdematous, and the physical examination of the left side of the chest showed dulness in the upper two-thirds, gastric resonance in

the lower third; in the upper half of the dull area bronchial breathing, in the lower half diminished or absent breath-sounds.

Post-mortem.—A firm, cancerous, growth was found invading the left bronchus, with the adjacent part of the lung and pericardium. The left bronchus was almost entirely obliterated and so was the left branch of the pulmonary artery. The arch of the aorta was narrowed. The left lung showed numerous dilated bronchial tubes, and scattered deposits of secondary growth. The rest of the lung was in a condition of general broncho-pneumonia, in most places having the appearance of caseation, in others forming small abscesses, with creamy green-yellow pus. The bronchial and mediastinal glands were enlarged by soft secondary growths.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Taylor.

Mary	41.	Fits. Slight aphasia. ? G.P.I.
	45.	Chorea. Arsenical neuritis.
	46.	Carcinoma ventriculi.
	47.	Mitral stenosis.
Philip	26.	Chronic intestinal obstruction.
	27.	Transverse myelitis.
	29.	Aortic disease.
	30.	Morbus cordis.
	32.	Pleuro-pneumonia.
	33.	Pleuro-pneumonia.
	35.	Pernicious anæmia.
	37.	Hodgkin's disease.
	38.	Phthisis.
	39.	Carcinoma ventriculi.
	40.	Gout. ? Pyæmia.

Cases under Dr. Hale White.

Mary	14.	Chronic bronchitis.
	15.	Cerebral tumour.
	16.	Pleurisy with effusion.
	17.	Localized peritoneal abscess. ? Appendix.
	18.	Dilated heart.
	20.	Mitral disease.
	21.	Mitral disease. Pregnancy.
	23.	Tubercular peritonitis.
Philip	1.	Pleurisy with effusion.
	3.	? Meningitis.
	4.	Acute rheumatism.
	5.	Pericarditis.
	7.	Mitral and tricuspid disease.
	8.	Phthisis.
	9.	Growth of stomach.
Philip	11.	? Cerebral compression.
	12.	Phthisis. Tubercular laryngitis.
	14.	Malignant growth of liver.
	15.	Gastric ulcer. Hæmatemesis.
	16.	Pericarditis.
	18.	Dilated stomach.
	20.	Mitral and aortic disease.

Cases under Dr. Pitt.

Mary	25.	Lobar pneumonia. ? Infective endocarditis.
	26.	Mitral stenosis and regurgitation.
	27.	Subacute rheumatism. Mitral stenosis.
	29.	Chronic tubal nephritis.
	31.	Gastric ulcer.
	32.	Carcinoma of liver.
	33.	Insular sclerosis.
	34.	Chronic bronchitis and emphysema.
	35.	Pulmonary regurgitation. Mitral stenosis.
	36.	Lobar pneumonia.
Stephen	21.	Chronic bronchitis and emphysema. Gout.
	22.	Left empyema after pneumonia. Operation.
	23.	Lobar pneumonia. Right base.
	25.	Pneumonia. Right base. ? Tubercle.
	26.	Lobar pneumonia. Right base.
	28.	Dilated stomach. ? Growth.
	29.	Right pleuritic effusion.
	32.	Left basal pneumonia.
	34.	? Insular sclerosis.
	35.	? Chronic tubal nephritis.
	36.	Appendicitis. Operation.
	37.	? Malignant disease of lung.
	38.	Acute nephritis.
	40.	Chronic dyspepsia. ? Carcinoma.
Cot.		? Typhoid.

Cases under Dr. Perry.

Mary	3.	Lichen planus.
	6.	Granular kidney.
	7.	Pernicious anæmia.
	10.	Diabetes.
	11.	Granular kidney.
Stephen	4.	Lardaceous disease.
	5.	Pneumonia.
	9.	Acute tuberculosis of lung.
	14.	Apical pneumonia.
	15.	Gastritis.
	20.	Rheumatism.

In the Surgical Wards.

Cases under Mr. Howse.

Astley-Cooper	14.	Extracapsular fracture of neck of femur.
	17.	Fractured anterior wall of frontal sinus.
	21.	Fractured femur.
	32.	Emphysema of back. Fractured ribs.

Job 2. Retained testis. Orchopexy.
8. Hare lip. Cleft palate.
9. Retention. Suprapubic puncture.
10. Hernia. Radical cure. ? Enlarged spleen.
23. Recurrent epithelioma of jaw. Resection of mandible.
25. Tubercular hip.
Lydia 5. Fractured pelvis. Torn perineum.
6. ? Adhesions after gastric ulcer.
10. Epithelioma on forearm in scar of burn.
13. Tubercular hip.
14. Fractured patella.
17. Talipes equino-varus.

Cases under Mr. Lucas.

Astley-Cooper 4. Ruptured vessel in leg.
9. Fractured femur.
17. Fractured patella. Indirect violence.
19. Stab in neck. Unilateral paralysis.
Lazarus 8. Old lupoid destruction of nose.
16. Tuberculous knee. Tuberculous ulceration of nose.
19. Anthrax.
22. Specific stricture of rectum.
Martha 2. Painful Syme's amputation. Trophic ulcers.
7. Fractured humerus. (Surgical neck).
20. Femoral hernia.
21. Psoas abscess.

Cases under Mr. Golding-Bird.

Cornelius 1. Fractured patella.
7. Extracapsular fracture of neck of femur.
10. Fractured pelvis.
Luke 8. Anthrax.
9. Extravasation of urine.
10. Vesical calculus.
Charity 8. Comminuted tarsus. Lacerated wound of foot.

Cases under Mr. Jacobson.

Astley-Cooper 31. Fractured ribs. Emphysema.
38. Depressed fracture of skull. Elevation.
Cornelius 2. Fractured tibia and fibula.
10. Fractured pelvis.
19. Compound tibia and fibula.
Naaman 3. ? Tubercular hip. Opened. Curetted.
6. Rodent ulcer. Excision.
7. Chondroma. 2nd & 3rd costal cartilages. Removal.
9. ? Sacro-iliac disease.
12. Lupus.
13. Hernia. Radical cure.
14. Tubercular abscesses. Scraped.
Dorcas 4. Movable kidney. Nephrorraphy.
5. Appendicitis. Removal of appendix.
10. Tubercular abscess over scapula. Opened.
Dorcas 11. Multiple tubercular lesions. Amputation left leg.
12. Suppurating pre-patellar bursa.
13. Tubercular knee. Excision.
14. Serous cysts of breast. Removal.
16. Atrophic scirrhus of right breast. Removal of breast.
17. Dermoid cyst in back. Removal.

Cases under Mr. Symonds.

Job 14. Gall stones.
16. Recurrent epitheliomatous glands in neck.
19. Ranula.
Lydia 19. Glands in neck. ? Lymphadenoma.
20. Floating kidney.
22. Fibroma of breast.
Patience 3. Ischio-rectal abscess.
15. Diabetic gangrene.
Samaritan 10. Peri-rectal abscess.

Cases under Mr. Lane.

Lazarus 13. ? Renal calculus. ? Tuberculous kidney.
14. Ununited fracture of femur.
Martha 10. Talipes equino-varus.
Samaritan 7. Ulceration and œdema on dorsum of foot.
11. Central abscess of fibula.

Cases under Mr. Dunn.

Luke 1. Hæmorrhoids.
3. Irreducible inguinal hernia.
10. Senile tubercle of knee.
Charity Cot D. Cleft palate.
Patience Cot. Erysipelas of scrotum.

Cases under Mr. Fripp.

Naaman 19. Hernia and varicocele. Radical cure.
20. Sinus in neck.
Dorcas Cot D. Inguinal hernia. Phimosis.

Nursing News.

Matron's Office.

The following Nurses have been successful in obtaining the Diploma of the London Obstetrical Society. Nurses R. Hockley, H. Newton, G. Reeve, and K. Finnemore (Hospital). Nurse Lawley (Institution).

Nurse Dewhurst, Head Nurse in Luke ward, has been transferred to the Out-patient department, and Probationer I. Wood has been appointed Head Nurse in her place.

Nurse Potter, Head Nurse in Bright ward, has been transferred to the Surgery, and Probationer B. Daniels has been appointed Head Nurse in her place.

The Decidual Cast.

By this is meant a cast of the interior of the uterus, composed of decidual tissue. The passage of such a cast may be due to:—

1. Tubal gestation. This is the usual cause.

2. Gestation in an imperfectly formed cornu of the uterus. This cornu is provided with a normal Fallopian tube and ovary, but its cavity does not communicate with the opposite cornu, which is well developed and represents the normal uterus. Fertilization, therefore, can only occur by transference of spermatozoa across the peritoneum from the well-developed to the imperfect cornu. There is a beautiful specimen of this malformation in our museum [Prep. 2517 (61)], but it is wrongly described in the catalogue as a ruptured *tubal* gestation. As a matter of fact, the right cornu represents a normal uterus and contains a decidua, while the left cornu is pregnant and is united to the right by a thin band of tissue. The pregnant cornu ruptured at the third month of gestation, and the patient died of internal hæmorrhage four hours later. I have met with two other good examples of this condition, both of which were mistaken for tubal gestation. The decidual cast comes from the normal cornu when gestation is interrupted on the opposite side.

3. Gestation in some form of divided uterus, such as uterus septus. One cavity becomes pregnant, and the other developes a decidua, which may be passed in due course. There are several specimens of double uterus in the museum, but none of them is pregnant.

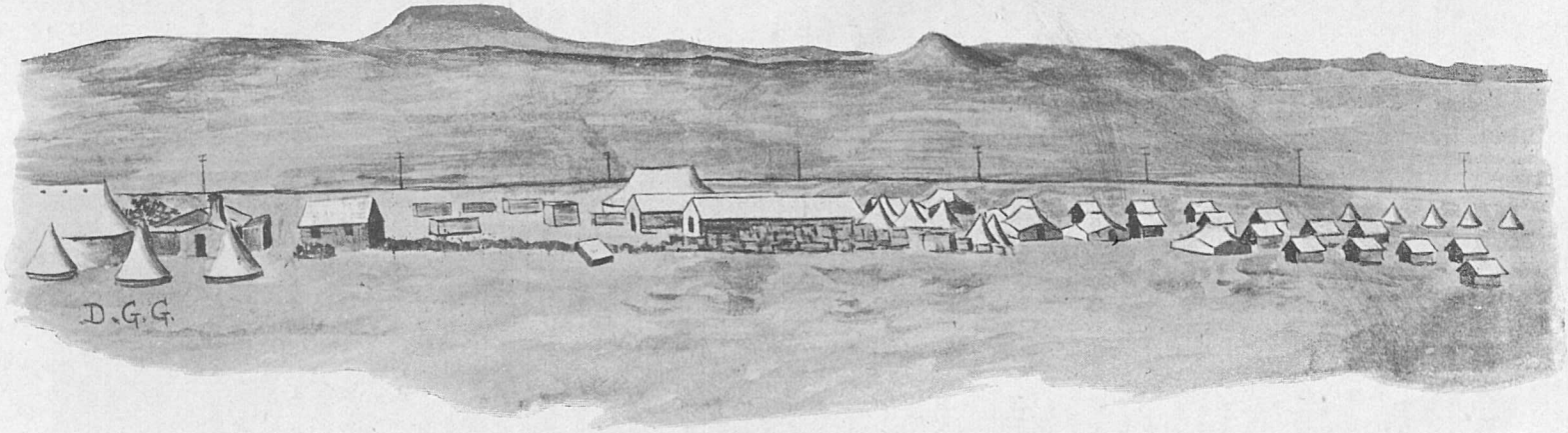
4. Some abnormal condition of an intra-uterine gestation.

5. Some abnormal condition of the endometrium, not associated with pregnancy. The discharge of decidual casts in the alleged absence of gestation has been described by two or three competent observers, though no satisfactory explanation has so far been given. Early tubal abortion may be followed by very complete involution of the tube, and thus the anatomical evidence of pregnancy may speedily disappear. That true decidual tissue can be produced without the stimulus of gestation is so contrary to general experience, that I think we are justified in not accepting these observations too readily, or at least in suspending judgment on them until more facts have accumulated. We will, therefore, direct our attention to the headings, Nos. 3 and 4.

An interesting case of divided uterus came under my notice last year. The wife of a medical man had vaginal hæmorrhage and passed a cast, which, on microscopical examination, consisted of decidual tissue. The first diagnosis, therefore, was tubal pregnancy, but two eminent specialists saw the patient and agreed that the gestation, if it existed, was intra-uterine. The size and completeness of the decidual cast, taken into consideration with the clinical evidence, led me to suggest that it was a case of divided uterus. The lady kept her secret for several months, and was eventually delivered of a full-time living child. A septum in the cavity of the uterus was then easily recognised, though there was no indication of division from the exterior of the organ.

Within the past few months there has been a case in Victoria ward which presented some difficulties in diagnosis. The patient was admitted for threatened abortion at the end of the fifth month of pregnancy. On two or three occasions during the previous fortnight, she had passed much watery fluid, as well as blood and clots. After attempts at induction of abortion, a large decidual cast was expelled. Though not complete, the portions belonging to the regions of the internal os and one of the uterine cornua were visible, and as the uterus was on a level with the umbilicus it seemed very improbable that such a large cast could come from an ordinary gestation at the end of the fifth month. The uterus was evacuated under anæsthesia and a partly macerated fœtus was removed. No trace of a division in the uterine cavity existed. The age of the fœtus, determined by the measurement of a femur, was five months. Evidently, in this instance, the decidua reflexa and vera had failed to unite even at the end of the fifth month, and the case was an example of hydrorrhœa gravidarum, due to the so-called decidual endometritis. In spite of the large size of the membrane passed by this patient, it was not a complete cast of the uterus, and was, therefore, insufficient to disprove the existence of an intra-uterine gestation. Hence it follows that the outline and completeness of the decidual cast are of no less importance than its structure in the diagnosis of tubal gestation. With regard to this structure, some writers make much of the difficulties in distinguishing a decidual cast from a dysmenorrhœal membrane. Thus, Mr. J. W. Taylor, in his book on Tubal Gestation, says: "There is no essential difference between the decidua formed in extra-uterine pregnancy and that which is formed in so-called membranous dysmenorrhœa." But surely this is going too far, and reminds one of those incompetent microscopists who love to harp on the resemblances of inflammatory tissue to sarcoma. I have examined a large number of these membranes and casts, and in my experience it is exceptional to meet with difficulty in distinguishing them. If the supposed cast is necrotic, or badly preserved, or in a very early stage of development, perhaps no reliable opinion can be formed. But in the ordinary course of events, the abundance and character of the decidual cells, the greatly increased vascularity, the large extravasations of blood into the tissue, and the hypertrophy of the glandular follicles are striking features of the decidual cast. The substances other than the menstrual membrane, which must not be confused with the decidual cast, are blood-clot, fibrinous laminæ, and epidermic exfoliations from the vagina. All of these are easily recognised by a naked-eye examination which will be confirmed by the microscope.

J. H. TARGETT.



IMPERIAL YEOMANRY HOSPITAL.

View from Hill behind Camp.

(*From a Sketch by* D. G. Greenfield.)

Passim.

By a great stroke of luck Dr. Bryant secured an ideal spring day on the occasion of his marriage. The seventeenth had upheld the best traditions of English April; rain had fallen incessantly during the day, and the night arrived in a cloak of heavy clouds, blotting out the face of the earth with dreary dank mists. Yet the eighteenth awoke to bright sunshine, birds in song, and trees in bud, and the hundred and one joys expected but rarely obtained in spring time. It was good to be alive; it was good to feel the warmth of the sun in the dirt-grimed Borough; but it was best of all to sit in the beautiful old church at Norwood and watch the sunlight on the flowers at the altar. And after the ceremony was over and the organ had played its tribute to the newly-wedded pair, we strolled up the hill to the house and dreamed away the sunny afternoon in pure enjoyment, with the contemplation of matrimony and tobacco. And when the time came for the departure of the bride and bridegroom we wished them a hearty God-speed, and gave them the message of the hospital—"Long life and happiness." There were many familiar Guy's faces, both past and present, among the guests; and there were many dresses, but on this subject we must perforce hold our peace.

We publish with this issue a reproduction of a water-colour sketch of the Imperial Yeomanry Hospital, by Mr. D. W. Greenfield. We also print some few notes which we have received from Mr. Fripp. From a letter which accompanies these notes we gather that he is extremely busy, both with surgical and administrative matters, and cannot see any immediate prospect of lighter times. And, as is only to be expected, he appears to be thoroughly happy and enjoying life to the full, although he spent the whole of one night bailing rain-water out of his tent! Apparently South Africa is very much alive with Guy's men. Wherever there is a good bit of work being done, there is found a Guy's man with his shirt-sleeves rolled up. And even in awarding the meed of praise to his operating theatre as the finest in South Africa, Mr. Fripp has to make one exception in favour of the Somerset hospital at Cape Town, "which C. G. Anderson has made very tip-top." Mr. Fripp is very proud of the Yeomanry Hospital and its work, and with good reason. It is one of the many factors which prove that in this branch of military science England is second to none. "Dr. Washbourn and Mr. Newland-Pedley and all 'the boys' from Guy's are going very strong. All of them are brown, and some of them are bearded, and not a few have got horribly fat—the voyage did that." Not altogether; one or two, it will be remembered, were comfortably adipose from the start.

We hear that the bicycle stable is now ready for use and that bicycle stands will be erected as soon as possible. It is to be supposed that there was some decidedly-expressed desire for such accommodation, otherwise these steps would not have been taken. For our own part we have never yet realized why men have not stored their machines in the hospital library; there is plenty of floor space there, and more might be obtained if the librarian insisted on readers sitting on the tables. The library has become such a recognised cloak-room for hats, coats and bags, that it seems only natural that its sphere of influence should be increased.

By now the illuminated address has reached its destination. As we announced in our last issue, it was duly on view in the offices, but only on the one day, Saturday. Many men availed themselves of the opportunity thus afforded of inspecting the whole thing, but for the benefit of those who were unable to see the original, we hope to publish, if possible, photographs which will give some, if inadequate, idea of the reality. The address took the form of a book, about sixteen inches by twelve, bound in half leather, with the covers cased in copper plates. The front cover bore a *repoussé* design representing Old London Bridge, treated conventionally, with the arms of Thomas Guy in the left hand corner. The back cover was sheathed in copper but quite free from ornament. The first page of the address was designed by Miss Fortescue-Brickdale and consisted of a draped female figure representative of Fame, and the address proper, the text of which has already been published. The remainder of the book was devoted to signatories, some thirty to the page, and this perhaps was the most interesting feature of the whole thing. Every signature had been traced, transferred, and then inked in on the parchment. By this means the signatures bore the characteristics of the original signatories, without the addition of other matter from unwashed hands.

During the whole of the Summer Session and the Summer Vacation, until October 1st in fact, Saturday post-mortem examinations are to be performed at twelve midday instead of two o'clock. This is a very useful and very wise step on the part of the hospital authorities. It is a recognition by them of the fact that the medical student, like the British workman, expects to enjoy a Saturday half-holiday, and that this is rendered practically impossible, to the keen man at any rate, by classes and demonstrations that cut into the best hours of the afternoon. For some time past there has been evinced a growing tendency to consult the wishes of the majority in the matter of times of lectures; perhaps in the future the nature, duration, and number constituting a "full course" of lectures, will be decided by the majority. Perhaps by then lectures will have gone the way of the powdered wig in our profession, and the Guy's man then know of nothing but clinical demonstrations. Then, perhaps, there will be no schedules!

By the death of Mr. Walter Clegg the hospital has lost one of her oldest students and journalism a famous old war correspondent. Mr. Clegg received his professional education at Guy's, and became a member of the Royal College of Surgeons in 1843, taking the L.S.A. a year later. Then journalism claimed him, and it is to his efforts that Lincolnshire owes the foundation of the *Boston Guardian*, the oldest penny paper in the county. At the outbreak of the Crimean War Mr. Clegg obtained a surgeoncy in the 2nd Battalion Rifle Brigade, and promptly went to the front. There his journalistic abilities led to his appointment as correspondent to the *Illustrated London News*, a post which he filled with considerable skill. Returning to Boston at the close of the campaign, he interested himself in municipal matters, was appointed Justice of the Peace in 1867, and held the mayoral chair in the two following years. He will be long remembered in Boston as Medical Officer of the Borough and Coroner for the Boston District of Lincolnshire, both of which offices he fulfilled with his accustomed zeal. His loss will be deplored by a large circle of professional and personal friends.

We notice that an old Guy's man, Mr. Kinsey-Morgan has been elected Coroner for the County Borough of Bournemouth. Previous to his election to this post, Mr. Kinsey-Morgan had served for some time on the Bournemouth Town Council, and only resigned this position in accordance with the standing order that prohibits the application of any Councillor for a post in the gift of the Council.

The administration of the hospital, in so far as it affects the student, at the present day runs in such smooth tracks that it is most difficult to conceive any condition of affairs when methods were arranged differently. The nice proportion of work to each of the classes of appointments, resident and otherwise, and the sense of necessity that pervades them, leads one to imagine that in the days when these appointments were not, the hospital must have been in a state of chaotic muddle. Of course such an idea is devoid of foundation, for it must be considered that the advance of medicine and surgery as sciences has entailed additions to the numbers of skilled workers in each division; still, the progression of these sciences can hardly be considered as advancing *pari passu* with the multiplicity of appointments, and there is no appointment which cannot be cited as, directly or indirectly, contributing to the welfare of the hospital. It would be of great interest to the present generation of Guy's men if the number and scope of offices held in former periods of this century were exhibited side by side with the present system, and we should be very glad to receive statements of this nature from old Guy's men.

We have to record the untimely death of Arthur William Nourse, R.N., in the Naval Hospital, Chatham, on April 8th. Surgeon Nourse entered Guy's Hospital in the winter of 1892, obtaining the Open Scholarship in Arts for that year. In 1898 he obtained the double qualification of the Conjoint Board, and in May of the following year entered the Royal Navy. His loss will be keenly felt by the many friends that he made in his life at the Hospital.

A proposal has been made that the Debating Society, which has lately been emulating the baytree with considerable success, should continue its meetings during, at any rate, the first half of the Summer Session. It is not suggested that it should continue on the same lines as those which governed the Winter sittings, but that it should resolve itself into a Parliament and discuss matters of State with the gravity associated with the dealings of the Lower House.

The plan adopted in Debating Society "Parliaments" is briefly as follows: One member of acknowledged oratorical skill is chosen, privately, as Prime Minister, and forms a Cabinet from men who are of the same political views as himself. An opposition is formed in a similar manner, and then at the first meeting of the House, business is conducted on the approved Westminster pattern. Everyone present on the evening is a representative of some constituency, generally chosen by himself, and by the voting of the members present the fate of the first Cabinet is decided. The Speaker of the House is, of course, in reality the president of the meeting; the clerks may be dispensed with, or the parts may be filled by the secretaries of the society. A great deal of amusement is always caused by these debates, more especially when the House contains members of a controversial frame of mind. So far the proceedings of the Debating Society have shown that such members are not wanting.

Our cheery little contemporary, *The Broad Way*, is evidently enjoying life hugely. The April number contains a humorous though apochryphal account of the "Farewell Symposium" which Westminster gave to Mr. Stonham and the Staff of the Imperial Yeomanry Field Hospital. To judge by sundry remarks in this article the journal has stirred up a hornet's nest in its very home; but, nothing daunted, *The Broad Way* gaily launches on a wordy warfare with the *St. Bartholomew's Hospital Journal*, and proceeds to, metaphorically speaking, "wipe the floor" with that paper. It will be interesting to the onlooker to see what reply the more staid journal will make to the remarks which have been hurled at its devoted head.

We have been asked to call attention to an announcement of the Lawn Tennis Club, which will be found in another column. Every facility will be given this year for the encouragement of practice and for the detection and advancement of latent genius. The deplorable condition of the smoking-room, bereft almost of every trophy, must stand as a warning to the sporting instincts of the hospital. Challenge cups this year must be regained. There are several which should never have left our walls, and several which would find the most suitable resting place in the College, and among these latter are the two Tennis Cups. We have no excuse for not turning out easily the best hospital team in London. The executive lacks nothing in keenness, and if only the men, more especially the freshmen, will rise to a realization of their responsibilities, we shall not have to complain on this score. The second team has a goodly array of fixtures already; no doubt more can be arranged if necessary. The final decision, however, lies outside the hands of the Committee, and rests with the men themselves.

The permanent quarters of the Henrietta Raphael Nurses' Home, and the new Sanitary Block are progressing with reassuring rapidity. It will be idle to hope, however, that the Park will be this year in a fit state for any prize-giving function; even if a sufficiently large space could be tidied up for the accommodation of the visitors, it is doubtful whether the surroundings—the necessary surroundings when huge building operations are in progress—would allow a "garden party" to be other than a hideous failure. We hope, however, that some of the fair green turf which salved the jaded eye, in the hot months of last summer, will be coaxed back to life, if only for the benefit of the privileged few. One can have too much *kharki*, especially in London.

The Finals have passed over us, leaving the inevitable joys and sorrows. Again, alas, the absurdity of examinations, both in commission and omission, has been forced upon us; and so it will always be until the old order changeth and giveth place to the new. Whether the reconstructed University of London, in its monumental palace, will seek towards the ideal, from our point of view, can be a matter for conjecture only. There is one consolation, however, in the fact that it will hardly be possible to conceive of more inadequate methods of gauging knowledge than those at present in vogue. Meanwhile, there is nothing to do but grin and bear it—and go up again.

We do not often have to complain of profuse contributions to the Editor's box in the colonnade. Latterly, however, in the weekly aquatic entertainment given by the bathmen, some few gallons of water have been poured into that receptacle, to the detriment of its contents. We might point out to possible admirers that contributions of a liquid nature should in future be securely packed, and preferably of some other fluid than water.

Some Notes on the Imperial Yeomanry Hospital.

In an undertaking of this sort and size, the unforeseen and unpreventable difficulties are at least as great as those which it was possible to see and by hard work to overcome beforehand, and they crop up just when the latter are overcome, and when one thinks that everything is going to be plain sailing. The necessary rapidity of our mobilisation in London rendered it quite impossible for any arrangements to be made so that the material should arrive in the order in which it was likely to be required, and also made it quite impossible for our business manager in London to adequately inform the man who holds a similar position out here. The consequence is that our enormous materiel of over eight hundred tons has been arriving piecemeal and higgledy-piggledy by every transport that has left England since the 23rd January, and it is still so arriving, a three-ton boiler here, a gift of a couple of hundred cigarettes there, and so on. But the greatest difficulty of all has been that of transport from the Docks at Cape Town up-country, 471 miles over a narrow gauge line with a single pair of rails all the way, except at the stations where the up and down trains cross. The rolling stock is very limited and is getting worn out. The gradients are often very steep, so that it is impossible to take more than a certain load on a train, and, worst of all from our point of view, the entire line has been commandeered by the military authorities.

I came up here on March 3rd with Colonel Sloggett and the seventeen other doctors and ten dressers, and one hundred personnel, in a troop train which took forty hours to accomplish the 471 miles. We found several tents of various kinds and our equipment and stores already shot out on to the side of the line, and a few tents put up for our reception and a force of fifty kaffirs engaged. No water had been laid on, so it had to be fetched from the tank at the railway station, some two or three hundred yards away. It is an excellent supply of really good water from a deep well, which has never been known to fail, and therefore is recognised as one of the important watering stations, and all trains up and down stop here. No fires were alight and no food stores unpacked, but it did not take our hungry men long to provide themselves with an excellent breakfast. Then we set to work on marking out the camp and on the erection of huts and further tents.

I returned to Cape Town and had several very busy days there with heads of departments, merchants, and so on, and had only just got through the necessary business when the nurses arrived in the Guelph, on the 15th. With great good luck we got a train for them with so little delay that had it been timed to start two hours earlier than it did they could not possibly have caught it. As we had been able to get the doctors away just as promptly, I was more than pleased that not a single day had been cut to waste, for one hospital I know of had the bad luck to be delayed for nearly a fortnight at Cape Town, eating their heads off at great expense. All accommodation and food there is very expensive now. The only decent hotel is crowded with officers going and coming through to the front, and with their wives, who seem to have come out in great numbers to be as close as possible to their husbands, and are flitting about offering their services to those connected with any branch of aid to the sick and wounded, begging for employment "in any capacity." Our nursing sisters were in number forty, with ten ward maids. It was not a very easy matter to arrange for the feeding of them adequately for a forty-hour journey. They arrived here just in time for the first train-load of sick and wounded, and now, the 26th, we have 230 beds occupied, and shall very shortly have a hundred more, although it will be some six weeks before we are fully established.

This is a very good site indeed as the country goes. The water, as I have stated, is plentiful and good, and, like the site itself, is completely uncontaminated, for with the exception of the station master's house, and another for the water engineer, and a small general store, there are no houses within many miles except those of two large ostrich farmers. The air well merits the term "champagne air." There is a kopje at our back, and we look forward over rolling plains of karroo to a grand view of hills some eight or ten miles away. So far we have not been very fortunate with the weather. Almost every day has been spoilt by either a gale, strong enough to blow down some of the tents, or else by heavy rain. The land consists of three or four inches of mould and then you come on to rock, into which the tent poles cannot be driven. Of course eventually we shall be almost entirely in huts, and, indeed, more than half of the patients and the sisters and ward maids are already so housed, but we and the men are in tents. The days are sometimes very hot, sometimes quite pleasant in temperature, but it is already getting cold at nights, and they say that in a couple of months it will not be an uncommon thing for an inch of ice to form on the top of the large tank at the station.

Murray-Guthrie has been spending a couple of nights with us on his way from Bloemfontein, where he has been appointed by Lord Roberts as chief distributor of medical comforts to the troops in South Africa, to Cape Town. Two days ago a Guy's man, Dr. Beadnell, jumped out of the train and popped in at our tent while we were having lunch. He was on his way to rejoin the Powerful with the Naval Brigade, with which he has been serving in all the battles on the western frontier. Rudyard Kipling, whose headquarters are with his wife and children at the Mount Nelson Hotel, often goes through on No. 3 ambulance train. On his journey up-country he messes with the two medical officers, Major Russell and Dr. Boswell, an old Guy's man, and as they come down from the front he writes the Tommies' letters. Thus you see we are constantly meeting people from the larger world and hear what is going on outside

our own little one, though really we are so busy now that days fly by without our noticing their passing and without giving us time to read or even to care very much about the "news," as one would call it at home. We get Reuter's telegrams every day and a good supply of newspapers from Cape Town, but few except the patients read them. The same does not by any means apply to the weekly mail of letters and papers from home. They are devoured with avidity.

I am very glad now that we accepted this site. What determined us not to wait for the prospect of going into the Orange Free State was the probability of the Norvals Pont Bridge being blown up, and now that this has actually happened it has of course delayed the onward move from Bloemfontein very greatly, and had we waited to take part in it or to put ourselves in Bloemfontein, we should still have been useless and expensive onlookers. As a matter of fact, it takes two hundred and forty tons to feed the troops and horses now in Bloemfontein each day, and the most that can be possibly taken across the pontoon bridge at Norval Pont is five hundred tons per diem, so that their empty storehouses in Bloemfontein can only be filled at the rate of one day's store per diem; in other words, it is next to impossible for Lord Roberts to make a big move for another three weeks unless the bridge can be repaired sooner than is expected, and even then it will probably take him three weeks to get to the Vaal River, so that it is not likely that a hospital in Bloemfontein will be in any great demand for another six weeks; meanwhile at this site we are doing most excellent work, and are having sick and wounded sent to us from Methuen's late route, as well as from Colesberg, Naauwpoort, and all that district, and also from the troops who guard the line to the south of us, and from the army which is going after the rebels to the west of us. In short, I think we could not possibly be in a more useful position.

We have suffered a good deal from an epidemic of diarrhœa and vomiting. Nearly everyone of us has been laid low. As a rule it lasts from twenty-four to forty-eight hours. In no case has it been at all serious but it leaves a weak feeling in the bottom of the spine. It is due, I believe, to the meat.

The medical and the nursing staff are realising all the high expectations I had formed of them. The hard work that was lavished in their careful selection has by no means been thrown away. Really it is rather a proud boast, but I think I can honestly say that there is not a single one amongst them that I would change even if I could. The sisters are a splendid body, and they are shaking down into their work, so very different in many ways to what they have been used to, admirably. The patients are one and all simply delighted to be here. One hears most amusing remarks at every turn—some call this hospital a palace compared with the places they have come from, and alluding to the feeding one said he thought he must have been mistaken for a prince!

The doctors have made a golf links, and we hope shortly to be playing cricket and quoits and rounders. We hope that our little wooden and iron house will shortly be able to be put up, but at present the material has not all arrived.

During the last week we have had 279 cases in the hospital, and this has been quite enough to keep every member, male and female, of the staff busy. The permanent operating theatre has not yet arrived from Cape Town, but in a temporary one in a curtained off end of one of the wards we have already had several operations, three major ones to-day for instance. What pleases me more than a little is the fame that our specialists in dental surgery and eye work have already acquired. Several cases have been specially sent to them from afar, and the services of both are being requisitioned as far as Kimberley. As I was a good deal criticised and even a little ridiculed for advising the inclusion of these specialists, it is very gratifying to me to find they are in so much request. ALFRED D. FRIPP.

"Religio Medici."

CANON GORE ON "PRAYER."

Summary of a lecture delivered in the Hospital Chapel on Monday, March 5th, 1900.

The lecturer began by recalling an experience he had had in a street in Calcutta—a naked fakir, who was travelling from that city to Benares, and measuring his length on the ground at every step. "My first feeling was indignation at the superstitious folly of the man, but that feeling was soon overtaken by a more worthy one. Here is a man, I thought, who knows far less than I do about God's real character, and yet what pains he is taking about his devotions! I felt rebuked by the man's earnestness, and asked myself, What trouble am I taking to cultivate and develope my intercourse with God?"

Looked at broadly, in the long reaches of history, human life may be observed to be moving out in three directions—(1) towards nature, to appropriate its resources, and the history of this movement is the history of civilisation; (2) towards one's fellow-men, and the history of that movement is the history of society; and (3) towards God. This movement is quite as perceptible and as important as the other two. It occupies, like the others, a large share of human effort and attention. It passes through similar stages. It has its rude beginnings in savage religions. Like civilisation and society, it has taken many different developments. But the aim of all these developments is realised in the religion and the prayers of the Son of Man, and of that great Catholic brotherhood which in His name worship the Father in spirit and in truth.

But to justify us in taking pains about prayer, we must believe in its efficacy. Yet numbers of people, who do not doubt the existence of God, doubt whether He really hears and answers human prayer.

The difficulties most commonly experienced are perhaps these—

(1). "Prayer is too childish. What is the use of asking God for things, when He knows so much better than we do what is good for us?" To ask this question shows a fundamental mistake as to the purpose of prayer. It is true that our Father knoweth the things we have need of before we ask him. But the object of prayer is never to inform God, but always to educate us in intercourse with Him. We are sons of God, capable of intelligent correspondence with our Father, capable of communion with Him. To train us now for this communion, in the childhood of our eternal life, we are to be practised to pray.

(2). A special difficulty is often felt in regard to the universality of law, and the supposition that we can in any degree influence the course of the world and the events of our own life by prayer. The whole subject of the relation of law to freedom is one of profound difficulty, yet practically we know in fact that, although about us and through us and in every fibre there is this succession according to law, yet somehow or other there is side by side with all that what we recognise as the reaction of our free will. In practical life everything depends for each of us upon how we react upon our environment. Just as there are vast stores of things—knowledge, wealth, reputation, etc.—which will not come to us unless we work, so also there are large classes of things which do not come to us unless we pray.

(3). "How can what *I* want in any way divert or alter the orderly working of those eternal processes which are God's purpose for the universe?" Here we get to the real point. For if prayer is an attempt to bend down the great laws of God's working to my narrow point of view—to the needs of me, a mere individual—then this objection is certainly valid. But prayer, properly conceived, is nothing of the sort. On the contrary, prayer is the way in which we enlarge our narrow points of view to the breadth of God's purposes. Prayer is the supremely effective way of corresponding with God. By prayer men learn precisely what they have learnt to do in natural science under the guidance of Francis Bacon—to control nature, material and spiritual, by obeying. Prayer is fruitful exactly in proportion as it is not an attempt to fight against the laws of God's government, but an attempt to co-operate with His purpose.

The lecturer concluded his lecture by showing how this idea of prayer was taught by Christ when He gave mankind the Lord's Prayer as the model of all prayer.

Chapel News.

The Annual Meeting of the members of the Chapel congregation will be held on Wednesday, May 2nd, at 8.15 p.m., in the Board Room. The business of the meeting is to elect the members of the Chapel Committee for the ensuing year and to transact other business. All members of the congregation are invited.

Wedding of Dr. Bryant.

On the occasion of Dr. Bryant's marriage to Miss Fry, a silver "Grecian" Bowl with a bas-relief representing the Elgin marbles, on ebony pedestal with mounts and shield bearing the inscription "Presented by the Students of Guy's Hospital to Dr. J. H. Bryant on the occasion of his marriage, April 18th, 1900," was given by students of the hospital. The following letter from Dr. Bryant has been received by Mr. J. A. Butler, who acted as Hon. Secretary to the Committee which arranged the presentation:—

4, St. Thomas's Street,
London Bridge, S.E.,
17th April, 1900.

My dear Butler,—As I know you have taken a very active part amongst the students in providing me with such a magnificent wedding gift, I am writing to thank you and to ask you if you would be so good as to convey my thanks to the students also. I thank them not only for their very handsome silver bowl but also for their kind wishes and congratulations. I need hardly say how much I appreciate the gift. I value it and prize it most highly and always shall do so. It will be placed in one of the most prominent parts of my house, for I can assure you I am very proud of it. My life as a teacher at Guy's has been a very pleasant one, and I am sure it will always continue so. The kind and sportsmanlike way in which the "Boys" have always helped me, and the attentive and courteous manner in which they receive me, makes teaching for me a recreation rather than a labour. I feel that anything I can say or write is totally inadequate to express how much I appreciate this valuable testimonial, this very tangible expression of good feeling. Again thanking you all,—Believe me, yours sincerely, J. H. BRYANT.

Pass List.

University of Cambridge, April, 1900.

EXAMINATION IN SANITARY SCIENCE.

V. J. R. Roberts.

ELEMENTARY ANATOMY EXAMINATION, APRIL, 1900.

The following gentlemen have passed the above examination:—

Messrs. J. M. Barrionuevo, O. Black, H. H. Carter, J. H. Clatworthy, J. Cook, R. Felton, G. Hamilton, R. M. Rendall, A. M. Roome, G. Russell, Richard P. Rowlands, R. O. Williams, D. Isaacs, A. Leeming, M. G. Louisson, W. T. P. Meade-King, M. J. Mottram, G. Nunn, J. M. W. Pollard, C. H. Reinhold, J. E. Spiller, J. D. Thomas, H. F. B. Walker, F. H. Wallace.

TEST EXAMINATION IN PRACTICAL DENTAL METALLURGY, APRIL, 1900.

Messrs. A. R. Beaumont, F. G. Day, E. J. Gaffney, C. D. Wood.

Reviews.

Aids to Pharmacy. Adapted for the Examination in Practical Pharmacy of the Conjoint Board, etc., and for General Use. By A. Campbell Stark, Demonstrator on Materia Medica and Pharmacy, at St. George's Hospital. London: (Baillière, Tindall & Cox) 2s. 6d.

To all *intents and purposes this is a note-book on* Pharmacy adapted to the requirements of the Conjoint Board. Small, concise, well printed, and unambiguous, it would be difficult to find a better hand-book for the class of examination for which it is intended.

Actions and therapeutics are omitted, in accordance with the Conjoint Syllabus; methods of preparation are brief, but sufficiently explicit for the guidance of those who, under any circumstances, would rely on the manufacturing chemist for their drug-supply. An excellent table of drugs, strengths, and doses, completes an admirable little book.

The Student's Handbook of the Surgery of the Alimentary Canal. By A. Ernest Maylard, M.B., B.S. Lond., Surgeon to the Victoria Infirmary, Glasgow, and Examiner in Surgery to the Victoria University. (London: J. & A. Churchill). Price 8s. 6d.

Mr. Maylard states on the title page that this work is an abridged and amended edition of a treatise on the same subject which was published four years ago. It is a book which should be welcomed by students and practitioners alike as a thoroughly practical work on the surgical diseases of the alimentary canal from the upper end of the œsophagus to the lower end of the rectum.

The author has briefly described the anatomy and physiology of each part of the alimentary tract before proceeding to the pathological conditions which may be found, and there are many beautiful photographs taken from specimens in the museums of the Glasgow infirmaries. The importance of skiagraphy is shown as a means of detecting the position of foreign bodies in the various parts of the canal, and Mr. Maylard says that it is not improbable that the near future will enable us to obtain shadow photographs of tumours of these regions.

The operations are described in a very lucid way, and the text is illustrated by numerous diagrams, which show the leading features of the methods employed. Special attention is paid to after-treatment, and the chapter on rectal administrations will be found most useful.

Mr. Maylard is to be congratulated upon the excellent way in which he has treated the subject, and we have no hesitation in strongly recommending his work to the notice of our readers.

The Broad Way for March is a particularly bright number. One article—on the relief of Ladysmith—is worthy of the much lamented *Guyoscope*, and we can give no higher meed of praise than that.

Also received. — Clinical Journal (6), Hospital (6), St. Mary's Hospital Gazette and Sports Supplement, St. George's Hospital Gazette (2), Climate, London Hospital Gazette, St. Bartholomew's Hospital Journal, Building News, Medical Temperance Review (2), Treatment (2), The Therapist (2), St. Thomas' Hospital Gazette, Polyclinic (2), Owens College Magazine (2), The Broad Way.

Notices.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Notice is hereby given that the next Primary and Final Examinations for the Diploma of Fellow will commence on Thursday, May 10th, and Monday, May 21st, 1900. Candidates are required to give not less than fourteen days' notice of their desire to present themselves for either of these examinations. Particulars relating to these examinations may be obtained of the Secretary (Mr. F. G. Hallett), Examination Hall, Victoria Embankment, London, W.C., to whom all applications in reference to examinations should be addressed. The required fees must be paid three days prior to the examination.

EDWARD TRIMMER, Secretary.

April 2nd, 1900.

Licence in Dental Surgery.

Old Regulations.—Notice is hereby given that the next examination will commence on Friday, May 11th, 1900.

New Regulations.—Notice is hereby given that the First Professional Examination will commence on Friday, May 11th, 1900.

Candidates are required to give not less than twenty-one clear days' notice in writing of their desire to present themselves for either of these examinations to the Secretary (Mr. F. G. Hallett), Examination Hall, Victoria Embankment, W.C., from whom all particulars relating thereto may be obtained.

April 2nd, 1900.

THE GULL STUDENTSHIP.

The Gull Studentship in Pathology and allied subjects will become vacant on the 24th June next. The studentship is open to candidates under thirty years of age who have studied in the Medical School of Guy's Hospital, is of the annual value of £150, and is tenable for three years. Further particulars may be obtained from the Secretary of the Board of Electors, to whom application must be addressed at the Office of the Medical School, not later than June 2nd, 1900.

Royal Army Medical Corps.

"COMFORTS FUND."

The following is an addition to the list previously rendered:—

	£	s.	d.
Henry, Percy F., Esq., L.D.S. (wrongly stated in last issue)	0	10	0
Rowland, W. J., M.B.	0	2	6

Sport.

Rugby Football.

1st XV. SEASON, 1899–1900.

A review of the past season does not give rise to much satisfaction; we commenced it as cup-holders, and with every prospect of remaining so, as nearly the whole of our forwards were again available. Owing, however, to an unfortunate train of circumstances, we were, during the earlier part of the season, in a constant condition of transition, while after a good display in the first and second rounds of the cup-ties, we failed to do ourselves justice in the semi-final, and after pressing hard for the greater part of the game, lost to what one cannot but consider a somewhat inferior team.

The changes in the personnel of the fifteen during the season are shown by the fact that thirty-nine men represented the hospital in twenty-one matches; of these eleven were won, eight lost, and two drawn; the most satisfactory results being victories over Richmond and Croydon, and the drawn game with Cooper's Hill. In the Cup ties we beat St. George's easily, Bart's after a hard tussle, and were unluckily beaten by St. Mary's.

In conjunction with St. Thomas's we played three games, all of which were lost, the combined team being, in each case, far from representative; to this fact may be ascribed the withdrawal of their offer of a fixture by Cardiff, and we may expect Blackheath to follow suit unless the two hospitals show more keenness about this match.

Sime and Thomas have proved themselves the most prolific try getters during the season, with Morgan a good third; while Louisson and O'Brien have been the most successful in goal kicking, a department in which the hospital is usually rather weak.

Next season we shall be without the services of Sime, Jackson, Trail, Trubshaw, and Manson, who are all out of their year, but there is plenty of young blood available, and we hope soon to see the Rugger cup back at Guy's. We cannot conclude this review without expressing our regret at the illness which has necessitated the retirement of Mr. Davies-Colley, who has for so many years been the enthusiastic President of the Football Clubs.

2nd XV. SEASON, 1899–1900.

Won 11. Drawn 1. Lost 9.

We had a fairly successful season, winning eleven matches, v. Kensington, St. Thomas's Hospital, Beckenham (2), London Irish, Old Merchant Taylors, Polytechnic, Lennox, Marlboro' Nomads and Streatham (2), drawing one match v. Westminster, and losing nine v. Lennox, Rosslyn Park (2), Croydon (2), Hammersmith, St. Bart.'s Hospital, R.I.E.C. and Sutton. Before Christmas we won seven matches, drew one, and lost three. In the Surrey Cup we drew a bye the first round and beat Lennox in the second, falling before Sutton in the semi-final. We were unlucky in losing Maling, Ring and Watson-Smythe who went to South Africa, and Wyatt who injured his knee early in the season.

Guy's Hospital Chess Club.

THE SHAW CHALLENGE CUP.

The following is the result of the first annual competition for the above cup.

	Dismorr	Kennard	Kitchen	Miller	Robinson	Russell	Stewart	Thomas	Total
Dismorr ...	×	1	1	1	0	1	0	1	5
Kennard...	0	×	0	½	1	0	0	1	2½
Kitchen ...	0	1	×	1	1	1	0	1	5
Miller ...	0	½	0	×	0	1	0	0	1½
Robinson	1	0	0	1	×	0	0	1	3
Russell ...	0	1	0	0	1	×	1	1	4
Stewart ...	1	1	1	1	1	0	×	1	6
Thomas ...	0	0	0	1	0	0	0	×	1

Mr. Stewart is accordingly first holder of the cup.

Guy's Hospital Lawn Tennis Club.

The Lawn Tennis Club opens the season at Honor Oak Park on Saturday, May 5th, with a trial match between Senior and First Year's men, but if the weather permit Harris will get a few courts ready for play on Saturday, April 28th.

It is hoped that all freshmen who play tennis will put their names down on the trial match notice, which will be duly posted in the smoking-room.

The club is running two teams again this season, and our first match is fixed for May 12th, by which date we trust our captains will have found teams which will bring back to us once again the Inter-Hospital Tennis Cups.

For the benefit of new men we may mention that the Junior Inter-Hospital competition was instituted last season, the cup being kindly presented by Dr. Washbourn. It was won by St. George's, who are therefore the first holders. We have decided, by permission of the

Clubs' Union Council, to run three more courts at the Brockley end of the ground. These are, however, not to be used in addition to the courts already down, but as reserve courts, to give the others a rest when worn. This must be clearly understood.

The competitions last season were very successful, and we hope to see the same keenness again this season in these tournaments.

There will be also the open championship tournament for the Lane-Washbourn Challenge Cup.

The singles and doubles are both handicap tournaments and men who wish to rise above the level of the "pat-ball" game cannot do better than follow Baddeley's advice and enter for all the handicap competitions that they possibly can, and to read his book on lawn tennis (1/-).

In conclusion, any member of the committee will be only too pleased to enlighten new men on tennis matters connected with the hospital.

FIXTURES FOR 1900.

1st VI.

May			
S. 5.	Trial Match	... ...	Home.
S. 12.	South Croydon	... ...	South Croydon.
S. 19.	Blackheath ...	... ...	Blackheath.
W. 23.	Sydenham ...	... ...	Sydenham.
S. 26.	Harold	... ...	Home.
June			
S. 2.	Kent Lawn Tennis Club	..	Home.
W. 6.	Weighton	... ...	Home.
S. 9.	Redhill	... ...	Redhill.
S. 16.	Past v. Present	... ...	Home.
W. 20.	Staff ...	... ...	Home.
S. 23.	Wanstead	... ...	Wanstead.
S. 30.	Mr. Hall's VI.	... ...	Home.
July			
S. 14.	Harold	... ...	Norwood.
S. 21.	Dulwich Park	...	Dulwich.

2nd VI.

May			
S. 5.	Trial Match	... ...	Home.
W. 16.	St. Thomas's	... ...	Chiswick.
S. 19.	London Hospital	... ...	Home.
W. 23.	Addiscombe	... ...	Home.
June			
S. 2.	St. Bart.'s ...	... ...	Winchmore Hill.
W. 6.	Addiscombe	... ...	Addiscombe.
S. 9.	Gipsy	... .	Home.
W. 20.	Gipsy	... ...	Stamford Hill.
S. 23.	St. Thomas's	... ...	Home.
July			
S. 7.	St. Bart.'s	... ...	Home.
S. 14.	Surbiton	... ...	Surbiton.
W. 25.	Sydenham	... ...	Sydenham.

E. N. JUPP, Hon. Sec.

Medical Golf Tournament, 1900.

The Tournament (open to all qualified men) will be held this year under Medal play regulations on Thursday, May 10th, at Wembley (by kind permission of the Wembley Golf Club).

The Committee have made the following regulations:—Competitors to form two classes—Seniors, 12 handicap and under; Juniors, over 12 handicap.

One round of 18 holes to be played. First and second prize in each class, as well as prize for last nine holes. Competitors may play over the course before playing their Medal round, which must be completed by 5 p.m. Members of Wembley Golf Club to play with two less than their handicap.

Entrance fee 5s. to be sent with entry, stating lowest handicap, to the Hon. Sec., Mr. Rolf Creasy, Windlesham, Surrey, on or before May 7th.

Foursomes will be arranged in the afternoon "Consultants v. Practitioners," gentlemen wishing to play should notify the Hon. Sec.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants in Medical Wards.—Messrs. R. W. B. Hall (Dr. Taylor); G. Clarke (Dr. Hale White); C. H. Glenn (Dr. Pitt); F. W. Sime (Dr. Perry).

Ophthalmic Dressers.—Messrs. F. D. Welch (Mr. Brailey, May 1st); P. W. L. Camps (Mr. Higgens, June 15th).

Surgeons' Dressers.—Messrs. D. R. T. Griffiths, T. H. F. Roberts, J. F. Douse, C. E. Gaitskell, A. C. Nash, E. Roberts (Mr. Howse); H. S. French, G. S. C. Hayes, W. M. Robson, A. W. Gater, A. W. Soper, H. K. Lacey (Mr. Lucas); M. D. Wood, R. Thompson, S. C. H. Bent, L. Hirsch, W. O. Roberts, E. F. G. Heap (Mr. Golding-Bird); F. Curtis, M. J. Rees, C. B. Penny, H. C. Keates, A. Wylie, G. G. Davidson (Mr. Jacobson).

CIVIL.

Adeney, E. Leonard, M.D. Lond., M.R.C.S., has been appointed Physician to the General Hospital, Tunbridge Wells.

Burrell, L. C., M.B., B.C. Camb., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Kew Sanitary District by the Richmond (Surrey) Board of Guardians.

Cadell, Nevil P., L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., has been appointed Medical Officer of Health by the Frimley Urban District Council.

Clowes, Ernest Francis, L.R.C.P. Lond., M.R.C.S., has been appointed Deputy Medical Officer for the Churfield District of the Thornbury Union.

Cooper, C. E., M.B., B.C. Camb., has been appointed Medical Officer for the Second District of the Plympton St. Mary Union, *vice* J. M. Randle, L.R.C.P., M.R.C.S., resigned, and Certifying Factory Surgeon for the Urban

District of Ivybridge, the Civil Parish of Ugborough, in Totnes Rural District, and the Civil Parishes of Cornwood, Harford and Ermington, in Plympton St. Mary Rural District.

Grace, Gerald, L.R.C.P.. Lond., M.R.C.S., L.S.A., of Chipping Sodbury, has been appointed Civil Surgeon to No. 10 General Hospital, South Africa.

Ham, B. Burnett, L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer to the Brigade of Guards at Pirbright Camp, Woking.

Holden, H. C., L.S.A., has been appointed Assistant Medical Officer to the Woolwich Union, *vice* W. Cowie, M.B., resigned.

Kinsey-Morgan, Augustus, M.D., M.R.C.S., has been appointed Coroner for the County Borough of Bournemouth.

Munden, Charles, M.R.C.S., has been re-appointed Medical Officer by the Langport Rural District Council.

Ormond, Arthur W., F.R.C.S. Eng., has been appointed Assistant-Surgeon to Out-Patients at the Royal Eye Hospital, Southwark.

Ritchie, R. H., M.B., Ch.B. Melb., has been appointed Public Vaccinator, at Horsham, Victoria, Australia.

Rix, B., M.R.C.S., L.S.A., has been appointed Surgeon to the General Hospital, Tunbridge Wells.

NAVAL AND MILITARY.

Surgeon-Lieutenant George Black, M.B., 2nd Volunteer Battalion the Royal Sussex Regiment, is granted the temporary rank of Lieutenant while serving in South Africa.

Surgeon-Captain L. W. A. Keiffenheim-Trubridge, Militia Medical Staff Corps, resigns his commission.

Lieutenant Alfred William Sheen, 3rd Volunteer Battalion the Welsh Regiment, resigns his commission, and is appointed Surgeon-Lieutenant.

Dr. E. T. Shorland is appointed a Medical Officer to the Imperial Yeomanry, with the temporary rank of Captain.

Arthur Stanley Wohlmann, M.D., has been appointed Surgeon-Lieutenant in the 1st Devon and Somerset Engineers.

Surgeon J. G. Watt, R.N., has been appointed to the *Esk*.

Lieutenant H. P. W. Barrow, R.A.M., has been ordered to South Africa on active service.

Surgeon-Major E. T. Crouch, A.M.R., has been appointed to the medical charge of Fort Grange and Fort Gomer and Browndown Camp.

George Arthur Wright is appointed Surgeon-Lieutenant in the Manchester companies of the Volunteer Medical Staff Corps.

Papers by Guy's Men.

Remarks on the Physical Signs of Pulmonary Disease. By P. H. Pye-Smith, M.D. Lond., F.R.S. — *Lancet*, 7th April.

A Case of Dermoid Tumour growing with the Spinal Canal, in which an attempt was made to remove the growth. By W. Hale White, M.D. Lond., and Alfred D. Fripp, M.S. Lond.—*Ibid*, 31st March.

The Reduction of the Deformity of Spinal Caries, based on 99 cases of angular deformity from Pott's disease treated by Manual Rectification. By Alfred H. Tubby, M.S. Lond., and R. Jones, F.R.C.S.—*Ibid.*

Micro-Organisms in Dental Caries. By Kenneth W. Goadby, L.D.S. Eng. *Dental Cosmos* for March and April.

Excision of the Cæcum for Ileo-cæcal Cancer. By J. T. J. Morrison, M.A., M.B., F.R.C.S.—*The Birmingham Medical Review* for April.

A Clinical Lecture on the "Riding Fragment" in Fractured Leg. By C. H. Golding-Bird, M.B. Lond., F.R.C.S. Illustrated and Special Plate.—*British Medical Journal*, April 21.

Swelling of the Eye-lids with Intermittent Albuminuria in Children. By Theodore Fisher, M.D., M.R.C.P. Lond.—*Ibid.*, April 14.

Case of Mediastinal Growth with Secondary Deposits in the Spinal Canal causing Paraplegia. By H. J. Campbell, M.D., F.R.C.P. Lond.—*Lancet*, April 14.

Clinical Studies. By W. J. Tyson, M.D., M.R.C.P.—*Clinical Journal*, April 25.

Birth.

RANDALL.—On March 15th, at Ascension, the wife of Philip N. Randall, M.B. Lond., Royal Navy, of a son.

Marriages.

BRYANT—FRY.—On April 18th, at St. Luke's, West Norwood, by the Rev. B. S. Lloyd, vicar of Lower Edmonton, assisted by the Rev. H. T. Hughes, vicar of St. Luke's, West Norwood, John Henry Bryant, M.D., B.S., M.R.C.P. Lond., Assistant Physician to Guy's Hospital, eldest son of the late William Mead Bryant, of Ilminster, Somerset, to Stella Beatrice, sixth daughter of Richard Henry Fry, Grecian Villa, Beulah Hill, Norwood.

SHENTON—HOLLIS.—On April 21st, at St. Laurence's, Catford, by the Rev. R. S. Gray, Edward Warren Hine Shenton, of Guy's Hospital, to Phœbe, daughter of A. B. Hollis, of Bombay.

Deaths.

CLEGG.—On April 16th, at Boston, Lincolnshire, Walter Clegg, M.R.C.S., L.S.A., Coroner for the Boston District, in his 80th year.

STUART.—On April 1st, at Fyzabad, Oudh, India, Helen Elsie, infant daughter of Major S. O. Stuart, R.A.M.C., aged 16 days.

NOURSE.—On April 8th, at the Naval Hospital, Chatham, Arthur William Nourse, Surgeon, Royal Navy, eldest son of Colonel Nourse, aged 26 years.

Ed.—S. H.

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Calendar of Coming Events.

May, 1900.

Sat. 12—Messrs. Lucas and Lane's take-in; Drs., G. S. C. Hayes and H. J. Gater; Cl., C. B. Thomson.
G.H.L.T.C., I., South Croydon, away.
G.H.C.C., II., Croydon, home.
Hos.-Scho. C.C., St. George's, away.

Mon. 14.—1.15 p.m. Clinical lecture by Dr. Galabin.

Wed. 16.—1.30 p.m. Clinical lecture by Dr. Hale White.
G.H.C.C., II., St. Thomas's, away.
G.H.L.T.C., II., St. Thomas's, away.

Thur. 17.—Messrs. Golding-Bird and Dunn's take-in; Drs., E. F. G. Heap and W. O. Roberts; Cl., B. W. Moss.
G.H.C.U., Students' meeting.

Fri. 18.—1.15 p.m. Clinical lecture by Mr. Symonds.

Sat. 19.—G.H.C.C., I., Surbiton, away.
II., Thornton Heath, home.
G.H.L.T.C., I., Blackheath, away.
II., London Hospital, home.
Hos.-Scho., C.C., Park, home.

Mon. 21.—Probable date of Final Fellowship Exam.
1st and 2nd year's Dental Students Exam., Conservation Room, for Prizes, at 9 a.m.
2nd year's Dental Students Exam. for Prize, at 2 p.m.

Wed. 23.—1.30 p.m. Clinical lecture by Dr. Hale White.
G.H.C.C., II., St. Bart.'s, home.
G.H.L.T.C., I., Sydenham, away.
II., Addiscombe, home.

Thur. 24.—Messrs. Jacobson and Fripp's take-in; Drs., C. B. Penny and M. J. Rees; Cl., G. Lewin.
G.H.C.U., Address by Dr. Maxwell.
1st year's Dental Students Clinical Exam. for Prize, at 2 p.m.

Fri. 25—1.15 p.m. Clinical lecture by Mr. Lane.

Sat. 26—Last day for applying to Registrar for Form of Entry for Intermediate M.B. Lond. Exam.
1st and 2nd year's Dental Students Laboratory Exam. for Prizes, at 9 a.m.
G.H.C.C., I., Beckenham, away.
II., Dulwich, home.
G.H.L.T.C., I., Harold, home.
Hos.-Scho. C.C., Sydenham Albion, away.

Guy's Hospital Gazette,

MAY 12, 1900.

Insular Sclerosis

CLINICAL LECTURE BY DR. NEWTON PITT.

November 4th, 1899.

GENTLEMEN,—We have in the wards at the present time a patient with a nervous lesion, to which Dr. Moxon first gave the name Insular Sclerosis; the term, however, has not come into general use, but is more often replaced by that of Disseminated Sclerosis, though the term Insular is preferable.

Our patient presents a very early stage of the disease, and so well illustrates the difficulties of diagnosis, that his case is admirably suited for discussion. I shall also draw your attention to another patient, who was in the wards last year, in whom we failed to make a correct diagnosis during her lifetime.

I do not know any disease of the nervous system in the diagnosis of which mistakes are more easily made than in the early stages of insular sclerosis.

Insular sclerosis is characterized by the dissemination of innumerable nodules of what are called sclerosis, although the patches differ histologically in some points from areas in other diseases to which the same term is applied; numbers of these areas are scattered throughout the whole of the nervous system, brain, spinal cord, and nerves. In such places the axis sheaths of the nerves disappear, while the majority of the axis cylinders persist; and the intervening neuroglia tissue is much increased in amount.

The symptoms in advanced cases are characteristic, and there is no difficulty in the diagnosis, the most typical being a mixture of paresis with rigidity, a scanning speech, nystagmus, and what is called an intention tremor, that is to say, tremulous or jerky movements of the muscles when the patient attempts to perform any definite action.

I will commence by reading to you the notes of the case which is now in the wards, and after the lecture the man will present himself for the demonstration of the main features. We have an excellent report drawn up by Mr. Wilkin, and without giving you the whole, I will pick out the essential facts. The man is aged twenty, by occupation a goods porter. He is a little uncertain as to whether his mother had some

nervous disease which ultimately was the cause of her death or not; otherwise there is nothing noteworthy in his family history, and so far as he is personally concerned, he has had excellent health, with the exception that for two years he has been liable every three months to attacks of headache and vomiting, associated with severe toothache and earache, with a chilly feeling, with pricking sensations and tremors. The attacks generally passed off within a few days. Eight months ago he noticed that his eyesight, which previously had been good, was troublesome, and he could not see very well. He noticed that the right eye was constantly moving, so that he could not keep it still, and the movements have increased; four months ago he was unable to read with any comfort on account of the letters running into one another in consequence of the unsteadiness of his eyes. On October 11th he had what he thought was a bilious attack, his legs felt weak and stiff; the foreman who saw him accused him of being intoxicated and sent him home. He denied that he had been drinking and was able to walk home. In walking home it was noticed that he swayed from side to side. He went to bed and stopped at home for three days and then he was practically all right, excepting that he complained of a little numbness and coldness in the soles of the feet, and when walking, this feeling was replaced by a feeling of "pins and needles." On the 14th of October, at his work, he was again accused of being intoxicated and was sent home. For the next three days he was unable to work, but returned on the 18th when he was again sent home for being drunk. His legs were much weaker, he swayed about considerably from side to side, and it took him three-quarters of an hour to get home, although he could manage it generally in twenty minutes. By this time everyone was commenting on his gait, and the feeling of numbness had extended up his legs to his abdomen.

When he was admitted into the ward, it was noticed that the legs were slightly rigid, that the rigidity sometimes entirely disappeared, and

Fig. 1.

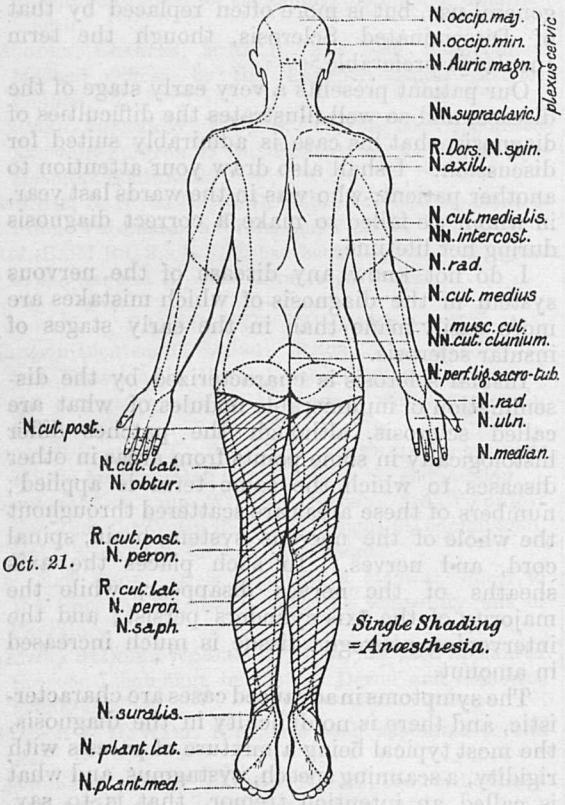
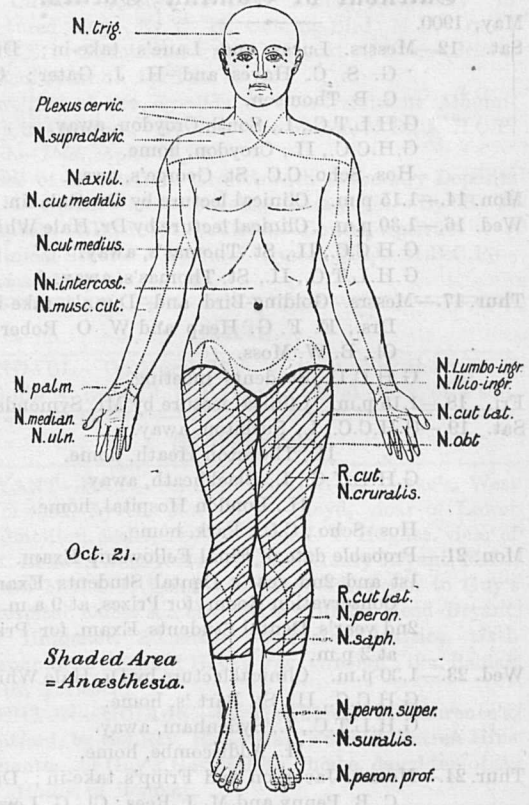


Fig. 2.



Figures 1 & 2 indicates the anæsthetic areas on October 21st.

was never very pronounced. The power in the legs was distinctly weak, and when he walked, he went very slowly and unsteadily, swaying about; he was slightly ataxic, the right leg being perhaps rather more rotated out than the left when he walked. He has nystagmus, which is constantly present, and is not merely induced by looking laterally at an object, as is more often the case. He has no marked intention tremors. When I first saw him, in addition to the weakness of the limbs, he also complained of a defect in sensation over his legs.

He has a deficient appreciation of touch over both limbs, with the exception of on the soles of the feet, where he was able to feel normally, and the line of demarcation was fairly transverse across the limb. He also had, in front, an area where he was unable to feel pain. The defects were partial, and not complete. On examining the man, we were at once struck by the suddenness with which these attacks had come on, by the irregular distribution of the weakness, which did not correspond to any definite paralysis, and by the unusual distribution of the anæsthesia.

As a rule, when the boundary of an area of anæsthesia runs across a limb, and corresponds to no peripheral distribution, it is functional in origin, and the anæsthesia in such case is usually profound. When there is organic disease producing an area of anæsthesia, it generally corresponds somewhat with the distribution of the peripheral nerves, or with some of the branches of the spinal nerves.

The distinction between the two is of importance. The cutaneous areas supplied by the various spinal nerves are still imperfectly defined, but they form elongated strips of various shapes running down the limbs, mapping out the surface. The cutaneous areas supplied by the respective levels of the spinal cord, also differ from those supplied by the respective spinal nerves, but remain to be accurately defined, still they also form elongated areas, with their long axes down the limbs.

The anæsthesia in the present case corresponds to none of these areas, but runs transversely round the limb similar to that met with in hysterical lesions, this distribution probably corresponds to a cerebral cortical distribution.

It should be borne in mind that a patient with an organic nervous lesion is more liable to have a superadded functional disturbance than a healthy person; this is not generally recognised, but some of the disturbances in cases of lead paralysis, chorea, etc., own this explanation. In the present instance, there is little doubt that there is a functional anæsthesia, superadded to the other symptoms, due to organic changes.

Upon examining him, the anæsthesia was found to vary at different times. Too much stress must not be laid upon this variation, because when there is partial anæsthesia a single touch may not be felt, yet the nerve may be able to transmit a repeated stimulus: and, on the other hand, you sometimes find, as regards motor power, that if the power of an affected ocular muscle, for example, is repeatedly tested, it tires, and the paralysis becomes more marked.

The knee-jerks were exaggerated, and on examining his plantar reflex we noted he had the *extensor reflex*. I propose to discuss this more fully later on, but what is meant, is, that on tickling the sole of the foot, instead of the toes, flexing as they do normally, they and especially the great toe, were over-extended. This is indicative of some defect in the lateral columns. At first I was inclined to look on his paralysis as functional, but we should then have left this extensor reflex unaccounted for. When, however, we went into his symptoms more fully, the presence of nystagmus at once attracted attention, and upon examining his optic discs, it was found that he had some partial optic atrophy involving both nerves, moderate in amount and rather more on the outer than on the inner side of the discs. His field of vision when tested was found to be but slightly limited.

It is quite possible that, had it not been for the nystagmus and optic atrophy, we might have persisted in the view that the condition was one of functional paralysis, in spite of the extensor reflex. But taking all the symptoms together, it was obvious that he was suffering from insular sclerosis, and this would also afford an explanation of the extensor reflex. In this disease a temporary paralysis is not infrequently an early symptom, while nystagmus and optic atrophy are not uncommon. At the same time the absence of the intention tremor and of scanning speech, two common symptoms, might easily cause the correct diagnosis to be overlooked.

To finish the report of the case. On the next day the anæsthesia had varied and had become much more limited. We had particularly noticed the presence of the transverse line of demarcation on the limbs. This anæsthetic area soon entirely disappeared from the leg, and an area of partial anæsthesia, with numbness, had appeared on the abdomen. Although he still walks very feebly and unsteadily, he does

Fig. 3.

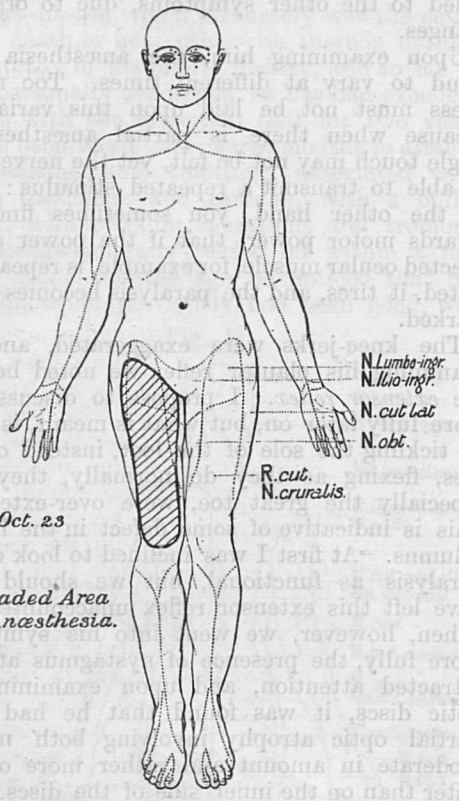


Figure 3 indicates the anæsthetic area on October 23rd.

not sway any more than he had done previously. With regard to his speech, it is not good; it is perhaps slightly slow and monotonous, but at the same time he has not the typical scanning speech met with at a later stage of the disease. With regard to his perception of colours, on the whole it was fairly good, but he confused light shades of brown with light olive-green, calling them both yellow, so that there is certainly some defect. Mr. Wilkin mapped out the fields of colour vision, they are somewhat limited, particularly laterally. The blind spot is rather increased in size, but the fields of vision for colours are not specially abnormal.

A gradual improvement then took place in his power of walking and the anæsthesia disappeared. I have very little doubt that the man will continue to improve and will be able probably to return to his work. This illness might very well have been considered to have been a case of hysterical paralysis, and he might have been told that he is perfectly well and will have no further trouble. In this lesion the period of quiescence varies; it may be a question of two, three, or five years before further symptoms develop. But almost without exception, within either a shorter or a longer period, further symptoms develop and the disease becomes perfectly characteristic and obvious. The handwriting is very often defective, but his is not abnormal.

There are many interesting questions to be discussed in connection with this case. Typical

Fig. 4.

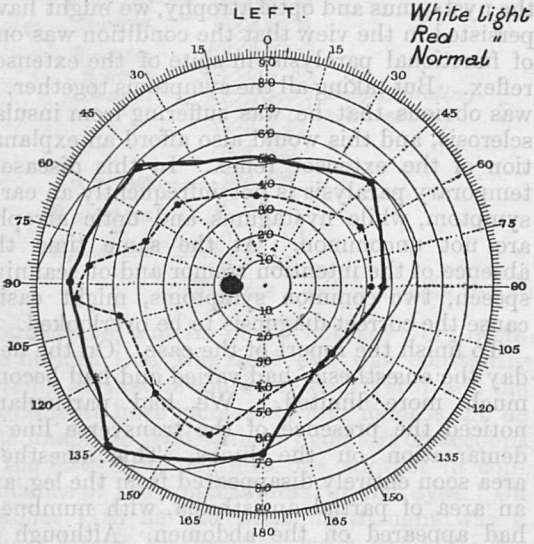
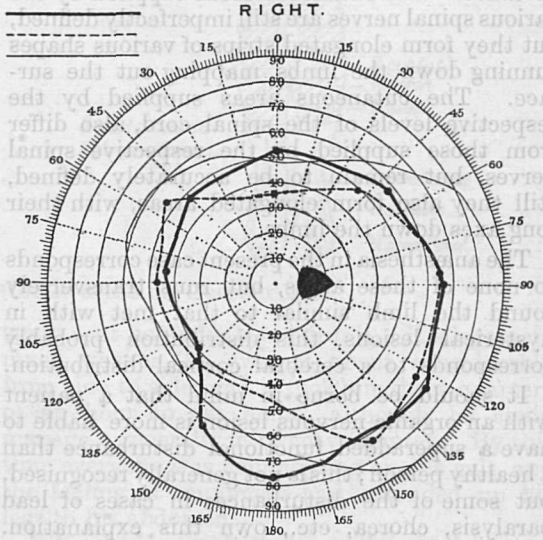


Fig. 5.



Perimeter Charts of the Fields of Vision for white and red.

cases are readily recognised and are not by any means rare, but the early stages are constantly being overlooked. Dr. Buzzard, some years ago, wrote a very interesting paper on the various cases in which he had diagnosed hysteria, but which further experience showed he had made a mistake. Almost all these turned out to be cases of insular sclerosis. I have seen several cases in which a diagnosis of hysteria had been made, but, owing to the presence of a little optic atrophy or nystagmus, watch has been kept upon them, and they have ultimately developed into a typical form of insular sclerosis. I now want to refer to the points of distinction in the symptoms between the early stage of this disease and hysteria, and it is to Dr. Buzzard that we are mainly indebted for the ready differentiation.

This disease consists of innumerable areas of sclerosis scattered throughout the nervous system. Consequently no two cases have the same areas, nor do the symptoms exactly correspond.

It is not easy at the time of the post-mortem to demonstrate the lesions satisfactorily, but when the cord has been properly hardened they are well defined [specimens shown]. There is the greatest divergence of opinion as to the cause of these areas of sclerosis. I have put down [here] a list of the more important symptoms.

In all cases, sooner or later, there is a variable amount of muscular weakness; it may be a quite slight paresis, a slight dragging of one leg, a tendency to tire readily, or it may amount to paralysis. But there is this characteristic, about which you should always be suspicious; in many, after a shorter or longer period, the paralysis diminishes and may entirely disappear. For instance, I am afraid the mistake in the diagnosis of a case that was in Mary ward last year arose from the fact of our overlooking this symptom. The patient, a woman, was twenty-five years old. Three years previously she had been unable to see with her right eye, and for three months had had paralysis of her right leg. She recovered completely from both these affections. Sufficient attention was not paid to these facts in the history and their importance was overlooked. Had due attention been paid to them, it ought to have made us suspicious that the disease was insular sclerosis. She came in, with a history of having fallen down one day; she then found her legs very weak, and complete paraplegia came on after a few hours, with retention of urine and fæces, the symptoms being apparently typical of an ordinary acute myelitis. She had complete anæsthesia and analgesia up to six inches above the umbilicus, with an area of hyperæsthesia. She had a plantar reflex, but no knee-jerks. She remained for many months with complete paraplegia, the amount varying but little, the anæsthesia gradually diminishing, but her condition did not alter much; her chief trouble was cystitis and the consequent mischief which was set up in the kidneys. After four months she recovered a little power in her left leg. Having come in, with what appeared to be an acute myelitis, and being an apparently typical case, the patient lying perfectly helpless in bed without any variation in the symptoms, she was not systematically examined from time to time, and finally she died after a miscarriage, and at the post-mortem insular sclerosis was found. Dr. Head who saw the patient some six week before she died, and was much interested in the disease, came to the conclusion at that time that it was a case of insular sclerosis, and his opinion turned out to be quite right. We made a mistake in neglecting the history of a partial paralysis of the ocular muscles and of those of the leg, which both cleared up in three months. Such mistakes are not infrequent, therefore I want to draw your attention to them particularly.

The next symptom in the disease which is of importance is *rigidity*. All the patients, sooner or later, develop more or less rigidity, which tends, as the mischief progresses, to increase slightly, and there are periodic attacks of spasm. When the rigidity is marked, if the patient attempts to bend up the foot, to micturate or to defæcate, convulsive movements may come on in the legs producing an exceedingly troublesome condition called spinal epilepsy, the attacks lasting for some time and occasionally for two or three days. When the attacks are brought on by moving the foot, firm flexion of the toes may put a stop to them.

Intention tremor.—This, when present, is very characteristic. In intention tremor the rate is more or less uniform, the tremor slow but increasing steadily in amplitude as the limb reaches the object it is wanted to touch. If a man wants to touch his nose, instead of moving his hand uniformly, the movements become very violent as the finger approaches it; when the muscles are at rest these movements cease. Consequently, when the patient is lying in bed the head is at rest; when the patient is sitting up the head is constantly trembling.

In some cases you find that the tongue when protruded is tremulous, and in others there is tremor of the vocal cords.

The number of muscles affected depends entirely upon the distribution of the sclerotic areas.

There is no characteristic gait. The patient may oscillate, he may have simply an uncertain, irregular gait with muscular weakness, but as the disease progresses the spasm which developes tends to increase the defect. There is a more or less uncertain, unsteady gait, with a tendency in the later stages to spasticity, and in some cases the spasm may be so troublesome as to make the erect posture absolutely impossible.

In a typical case the scanning speech is quite characteristic, and can be recognised instantly by anyone who has met similar cases. It is slow and monotonous; there is a difficulty in pronouncing such letters as "G," "R," "P," "D." The peculiar drawling intonation is difficult to describe, but, once heard, is readily associated with this disease.

Nystagmus usually is only present when the patient looks at an object, and, as a rule, there is only lateral nystagmus, that is when you tell a patient to look laterally at an object, instead of remaining steady the eyeball is constantly jerking back towards the middle line. Occasionally there is a vertical or a rotary nystagmus, and more rarely it is constant. In many cases an ocular muscle is paralysed for a time, and in consequence the patient has diplopia.

The constant movement of the eyeballs tends to interfere with accuracy of vision and the difficulty may be very great. In this man whose nystagmus is constant, his vision has become so defective, and he can only read $\frac{6}{60}$. It is therefore quite impossible for him to read a book; also, in consequence of optic atrophy the field of vision is slightly limited, in some cases it is considerably so, but as the atrophy is rarely extreme, the field of vision is only moderately limited. In many cases in the centre of the field of vision there is an area due to the optic atrophy which is completely blind, producing a scotoma.

Dr. Buzzard has drawn attention to one very interesting observation in some cases as to the colour vision. The field of vision for colour is smaller than that for form, and between these two areas a small red disc on a piece of white paper will be recognised by the patient as black. On the other hand, a green disc on a piece of black paper will be called white. I do not know that this condition has been noted in any other disease. The field of vision for colour is always less than that for form, but the misnomenclature is peculiar.

Sensory disturbances are rarely very marked. There are complaints of numbness, or the patient has a feeling of "pins and needles," and his feet may feel uncomfortably hot or cold. At times there is anæsthesia, this varies with the area affected. If there is a patch of sclerosis in the posterior columns, a certain amount of interference with sensation results, but there is not the complete anæsthesia met with in some other diseases. The sensory disturbances are moderate and variable, and not at all characteristic, and as a rule there is no great loss of muscle sense. The patient knows the position of his limbs with his eyes shut as well as when they open. Occasionally, but not habitually, there may be a loss of muscle sense. In quite exceptional cases, where the posterior columns are involved, there is distinct ataxia, and where the anterior columns are involved, muscular atrophy. These are exceptional conditions, still they do occur.

Besides the above symptoms, there are three physical signs to which attention should be drawn: the extensor plantar reflex, the exaggerated knee-jerks, and the partial optic atrophy.

The first stage of the disease varies from one or two up to four or five years, during which period there is a great tendency for the correct diagnosis to be overlooked. But when the second stage is reached, and there are well-marked rigidity of the legs, intention tremor, scanning speech, and nystagmus, the diagnosis is clear. In the course of years the rigidity increases, and finally the patient has periodic attacks of spasm, in which the limbs, more particularly the legs, tend to become fixed in various positions owing to the secondary contraction of the muscles. The most typical spasm is an extensor one, with the legs extended and the foot bent down; the spasticity varies from day to day, with exacerbation from time to time. But in some this is followed by flexor spasm, and the patient may lie in bed with the legs drawn up close to his body, and the heels touching the buttocks. In either case, the tendency is for the muscles gradually to contract so as to fix up the limbs in one position, and consequently it becomes impossible for the patient to get about; he becomes bedridden, and sooner or later he is carried off by various complications such as bedsores, cystitis, pyelonephritis, or pneumonia. The duration of the disease is to be measured by many years. Occasionally patients

may only live four or five, but many last fifteen or twenty years, leading in the latter part a most miserable existence.

After the disease has lasted for a few years, the *mental changes* are very characteristic. The patients laugh very readily, they may be very foolish, they cry unreasonable, and they are very emotional. In some cases the mental feebleness becomes even more marked. The tendency to laugh is sometimes a fairly early symptom. Two or three cases in the hospital were constantly roaring with laughter, without reason.

Optic atrophy.—The recognition of this as an important symptom is very largely due to Dr. Buzzard. Upon going through his series of cases he found that about 45 per cent. showed optic atrophy. When discussing the question of optic atrophy as part of a general nerve lesion, he found that optic atrophy was very much more common in insular sclerosis than in tabes. In tabes, optic atrophy does not occur in more than 15 per cent. of the cases, whereas in insular sclerosis it occurs in 45 per cent. He noticed also, on examining the record of a large number of cases, that there were about the same number of each. But there is this marked difference: the optic atrophy of tabes is one which is usually, sooner or later, complete, and very often ends in absolute blindness. Being complete it is usually recognised. The discs become grey, the pupils are very small, and the condition is not preceded by any optic neuritis. In cases of insular sclerosis the optic atrophy is very partial, and very often there is a great divergence of opinion as to whether atrophy is present at all. It very seldom occupies the whole disc. In perhaps the majority of cases the atrophy is fairly marked in the temporal half and there is a partial atrophy, not at all striking, occupying the temporal half of the disc, and for this reason this lesion is apt to be overlooked. In the case of this lad there is no doubt that he has some atrophy, but it is by no means at all well marked.

It is therefore clearly proved that when there is optic atrophy, particularly if it is partial, together with a central scotoma or limited field of vision, the possibility that insular sclerosis is developing should be borne in mind.

Ocular paralyses appear to be due to small patches of sclerosis appearing in the nerves just as they do in other parts of the nervous system.

(*To be continued*).

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Taylor.

Mary	38.	Tubercular peritonitis.
	39.	Phthisis.
	40.	G. P. I.
	42	Pneumonia.
	43.	Ascites. ? Cirrhosis.
	45.	Chorea. Arsenical neuritis.
	46.	Secondary carcinoma in liver.
	47.	Mitral stenosis.
Philip	23.	Pleurisy.
	24.	Typhoid.
	25.	Myelitis.
	29.	Double pneumonia.
	31.	Locomotor ataxia.
	35.	Pernicious anæmia.
	36.	Dilated stomach. Ascites.

Cases under Dr. Hale White.

Mary	15.	Cerebral tumour.
	20.	Mitral stenosis.
	23.	Tubercular peritonitis.
	24.	Enteric.
	Cot 54.	Tubercular peritonitis.
Philip	3.	? Malaria. ? Meningitis.
	5.	Pericarditis.
	7.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
	8.	? Intra-thoracic growth. ? Aneurysm.
	9.	Dilated stomach. Growth.
	12.	Phthisis. Tubercular laryngitis
	14.	Enteric.
	16.	Adherent pericardium.

Cases under Dr. Pitt.

Mary	26.	Mitral stenosis and regurgitation. ? Pulmonary incompetence.
	28.	Thrombosis of right femoral vein.
	29.	Chronic tubal nephritis and failing heart
	30.	Left hemiplegia.
	31.	Perforating gastric ulcer.
	32.	Carcinoma of liver.
	33.	Anæmia.
	34.	Hypertrophy and dilatation of heart.
	35.	Pulmonary incompetence.
	36.	Right pleuritic effusion and ascites.
Stephen	21.	Diabetes mellitus.
	22.	Empyema.
	23.	Lobar pneumonia.
	25.	Aneurysm of 1st part of aorta.
	29.	Left pleuritic effusion.

STEPHEN 31. Chorea.
33. ? Sclerosis of posterior and lateral columns.
37. Malignant disease of lung.
38. Acute nephritis.
39. Dyspnœa. Morbus cordis.
40. Obstruction of lower end of œsophagus
Cot. ? Typhoid.

CASES UNDER DR. PERRY.

MARY 1. Chorea.
2. ? Gastric ulcer.
3. Aortic regurgitation.
9. Enterica.
10. Perihepatitis ? Aortic aneurysm.
11. ? Myelitis.
Cot 52. Broncho-pneumonia.
STEPHEN 3. Enterica.
6. Mitral stenosis.
7. Aortic aneurysm.
8. Aortic regurgitation. ? Stenosis.
16. Tubercular peritonitis.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

ASTLEY-COOPER 21. Concussion. Fractured base of skull.
27. Lacerated leg. Ruptured posterior tibial artery.
32. Thyroid dislocation of femur.
JOB 1. Multiple sebaceous cysts of scalp. Excised.
5. Strangulated inguinal hernia. Kelotomy.
7. Anthrax of face. Excised.
8. Epithelioma of lip.
LYDIA 11. Appendicitis.
Cot C. Congenital umbilical hernia.

CASES UNDER MR. LUCAS.

ASTLEY-COOPER 17. Cut tendons and ulnar nerve.
LAZARUS 3. Varicose veins.
4. Secondary epitheliomatous glands in neck. Excised.
22. Reducible inguinal hernia. Radical cure.
MARTHA 3. ? Vesical calculus.
15. Tubercular periostitis of tibia.
Cot A. Old anterior poliomyelitis with secondary talipes varus.

CASES UNDER MR. GOLDING-BIRD.

CORNELIUS 1. Fractured patella.
5. Spiral fracture of tibia.
7. Extracapsular fracture of femur.
LUKE 6. Ununited radius. Wired.
8. Anthrax of neck. Excised.
LUKE 9. Stricture of urethra. Extravasation.
10. Vesical calculus. Lithotrity.
CHARITY 6. Strangulated femoral hernia. Kelotomy.
10. Carcinoma mammæ. Amputation of breast.
12. Tubercular arthritis of hip.

CASES UNDER MR. JACOBSON.

ASTLEY-COOPER 6. Lacerated wound of leg. Pneumonia.
15. Fractured ribs and sternum.
22. Cut throat. Enlarged prostate.
31. Fractured ribs. Surgical emphysema. Empyema.
CORNELIUS 7 (and Strong Room). Lacerated wound of leg. Ruptured urethra. Cut throat. Alcoholic mania.
15. Fractured olecranon. Wired.
NAAMAN 1. Exostosis of coracoid. Removal.
6. Epithelioma linguæ. Excision.
7. Epithelioma linguæ.
9. Hæmorrhoids.
10. Lupus vulgaris. Scraped.
DORCAS 3. Tubercular abscess of thigh. ? Hip. Broncho-pneumonia. Opened and irrigated.
8. Fibro-adenoma of breasts. Removal.
10. Abdominal tumour. ? Cause.
18. Tubercular abscess and spinal caries. Opened and curetted.
Cot B. Mastoid abscess. Antrectomy.

CASES UNDER MR. SYMONDS.

JOB 16. Cleft palate.
LYDIA 21. Chronic mastitis.

CASES UNDER MR. LANE.

LAZARUS 12. Ununited fracture of patella.
MARTHA 10. Tuberculous arthritis of knee.
PATIENCE 14. Epiphysitis of elbow. Abscess.
SAMARITAN 12. Punctured wound of axilla.

CASES UNDER MR. DUNN.

LUKE 2. Varicose veins.
3. Inguino-scrotal hernia.
CHARITY Cot D. Retro-phalangeal abscess.
19. Cricoid aneurysm of occipital artery.
PATIENCE 4. Cancrum oris.
SAMARITAN 7. Erysipelas of trunk and limbs.

CASES UNDER MR. FRIPP.

NAAMAN 19. Tubercular ankle.
20. Suppurating dentigerous cyst.
22. Inguinal hernia. Radical cure.
DORCAS 20. Ascites. ? Cause.
22. Secondary sarcomatous glands in neck following amputation right upper limb. Removal.

The Aetiology and Prognosis of Epithelioma of the Tongue.

[Read before the Physical Society by Mr. F. G. Gibson, and received the Society's Prize.]

MR. PRESIDENT AND GENTLEMEN,—In bringing this subject before your notice for discussion, I crave your indulgence; it has been treated so exhaustively by men of such high standing and wide experience in the profession, that one feels it would be presumption to attempt to adduce any theories of startling novelty, and accordingly you will be able to detect little of this quality in my remarks.

Whilst under a promise to read a paper before the Society, and casting about with many shadowy ideas for a subject, Mr. Fagge suggested the present form of research, not as one likely to unearth rich mines of thought, but as continuing, and bringing up to date a structure planned in past years, and still unfinished.

I have found tables of cases extending over the eight years 1867–1876, which comprise 46 cases admitted for excision of tongue into Billroth's Klinik, also 48 between the years 1877–1880 tabulated by Woelfler, and a very complete table of cases treated for epithelioma of tongue in the wards of University College Hospital, January 1st, 1871, and January 1st, 1882, comprising in all 60 cases.

To these I have been able to add a table of 95 cases admitted to the wards of Guy's Hospital during the years 1894–1898 inclusively, for treatment of the same malady, whether operated on or unoperated on.

I have attempted to arrange my table in the same form as that of Mr. Barker, of University College Hospital, so as to ensure fair comparison between the results of the methods of different dates and schools.

To complete my tables from the point of view of prognosis, I have sent out return post cards to the patients' friends, or medical attendant, whenever a definite address was obtainable, and have no reason to complain of the result, as out of eighty post cards sent out, only twenty-six were returned undelivered by the post office, while of these the officials of that department gratuitously informed me of the definite decease of three addressees.

I have thus received fifty-four replies, giving the date and cause of death, as far as was known to the patients' friends. In one reply tragedy was blended with comedy, as I was informed by a sorrowing daughter, that "your post card came late last night, and my poor father died sudden at 5 o'clock this morning." For days I went about dreading a summons to show cause why I should not be indicted for manslaughter. My enquiries were regarded as impertinent by one widow who called in person to know who I was, and what I wanted. I left her to the soothing influence of a brother extern, whose diplomacy secured the information I required without further ruffling the lady's feelings. From the majority I received expressions of gratitude for my kind remembrance of their relatives and friends; or, in the case of the survivors, thanks for the kind treatment received by them at Guy's.

My remarks, then, will be chiefly comparative; the data being drawn from my tables which, like those of Mr. Barker, have been arranged under the following headings:—Sex, age, abode, first evidence of disease, when and where noticed, condition on admission, whether glands were enlarged and where; ætiological data, (1) hereditary, (2) smoking, (3) syphilis, (4) local irritation (5) precancerous conditions; date and mode of operation, immediate result, date and cause of death, ultimate result, and approximate interval between first recorded appearance and death, stated in months. This arrangement is a slightly modified form of that used in compiling the University College list of cases, and I shall be pleased if members of the society will glance at them afterwards, as I do not propose to weary you by reading them, except in certain typical or peculiar cases. The first point which suggests itself is whether locality has anything to do with the production of epithelioma. This is a difficult question to decide for want of extensive and accurate statistics, and nothing could be more fallacious than arguments adduced from a hundred cases such as those I have collected.

Mr. Barker is inclined to make much of the fact that a considerable proportion of his sixty cases come from Wales, two being fellow-countrymen and hailing from the same foundry; this, I consider, a mere coincidence, and I could with equal justice assert that a large proportion of my own collection of cases come from the same principality; a fact probably due to the number of Welsh students who have been at Guy's, and who, on their return home, would naturally refer special cases to their own hospital. I might, again, point out that many of the Welsh cases have been treated by one particular surgeon at our hospital, who is held in the highest esteem in their district. I might also assert that a proportion, almost as large, comes from Woolwich and its neighbourhood, a fact which I regard as due, in the first case to their having been under the care of the Arsenal doctor, whose notes of recommendation are very familiar to the dressers in the front surgery, and also to a more far-reaching cause, namely, the probability of such cases, having served in the army on foreign stations, and having accordingly been liable to the contraction of syphilis, which I shall point out must be regarded as a prime factor in the occurrence of epithelioma. One might be disposed to refer this prevalence of tongue diseases in certain places, rather to the hard living of congested parts, or great cities with their habits of smoking and spirit drinking. In reference to this I understand from von Winniwarter, who tabulated the cases of Billroth's Viennese Klinik, that in Eastern countries, where smoking is even more common than in Europe, cancer of the tongue is little known, and, again, that among one hundred cases of lip and tongue cancer collected by Hertaux in Finistère, where the majority of the women are stated to smoke short pipes, there was not a single female case.

This brings us on to the question of sex, and an examination of various tables, comprising in all 293 cases, shows of males 247 cases, of females only 46; that is 15·6 per cent. of females to 84·3 per cent. of males, while in my own list of 95 cases there were 8 females to 87 males, or a percentage of 8·4 females and 92·6 males. The reason for this preponderance of male to female cases is only partially explained by a study of ætiological details. Perhaps there is some natural law of the balance of pain, for it must not be forgotten that the tongue stands about third in the common cancers, the breast and uterus taking first and second positions, so that in a total of 1568 mixed cases, 1006 were females and 562 males; but subtracting 794 cancers of the breast and uterus from these, there remain only 212 females affected to 562 males, showing that, when the breast and uterus are excluded, cancer is much more frequent in males than in females. However, in the course of my examination of the details of ætiology I hope to bring up some points on this question which may give rise to fruitful discussion.

Age.—In the next place, the time of life at which epithelioma shows itself must be carefully examined, and here I find a close resemblance between my own and other tables. The extremes of age are given by Mr. Barker as 26 and over 80; in my list they are 30 and 78 years respectively. The combined lists of seven records show the following arrangement as compared with my own:—

Years	20–30	30–40	40–50	50–60	60–70	70–80
Combined lists cases	8	35	88	94	52	12
My own ...	0	3	17	43	25	7

The bulk of the cases, then, lie between the ages of 40 and 70, or, on more accurate examination, between 45 and 65.

This fully bears out the teaching of Mr. Jacobson, namely, that chronic lesions, no matter in what organ, which are lightly treated in early life, become of the gravest importance when the prime of life is past; the tissues are no longer renewing themselves, but are degenerating—man has arrived at the stage of the sear and yellow leaf, no longer does the sap rise in the trunk of the life tree; its branches show no growth, its vertex is reached, and it becomes the unresisting prey of the canker and fungoid growth.

As to the forms of local irritation which may give rise to the disease; like other parts of the body prone to malignant growth, the tongue and mouth are subject to constant wear and tear; the injuries to which they are liable, are many. Among those met with in my list of cases are, (i.) bites due to severe falls, or repeated from time to time; (ii.) the chafing of a decayed tooth, or stumps, or even to a badly fitting false set; (iii.) the rubbing of a clay pipe, smoking new pipes, chewing strong tobacco; (iv.) drinking neat spirits; and (v.) the practice of carrying brass rivets, or nails, in the mouth while at work. I think it useless to try to indict any one of these as the common cause of local irritation, which has given rise to malignant growth; for in many cases two or more causes are found in combination,—for instance, taking the patient's statement of the apparent cause of the primary sore, I find that tobacco heads the list with a total of 53; teeth coming in a good second with 52; while direct injury is represented by six cases, examples being—a fall from a horse, with severe bite to tongue, and subsequent lock-jaw; or a fall down the hold of a ship, resulting in a badly bitten tongue. A carpenter blames himself for converting his mouth into a nail pouch, while another gentleman considers he poisoned his tongue by eating bad fish, and another blames the dentist who let his forceps slip. One candid patient gives the following account of himself:—an inveterate cigarette smoker, an opium eater for fifteen years, and a habitual drinker of neat spirits, to which practices he attributed his sore. Burns on the tongue are dangerous too, cases being cited of sores originating in burns made by the application of the wrong end of the cigar. Above all, the irritation due to habitual and excessive smoking is, no doubt, dangerous, not only on account of the constant stream of hot vapour which impinges on a small portion of the tongue, but also from the acrid products of dry distillation present in tobacco smoke. Of these, carbonate and acetate of ammonia, carbolic and acetic acids, which have been shown by Professor Ludwig to be present in relatively large quantity, are probably especially injurious. Their prolonged action is stated to give rise in certain persons to chronic superficial glossitis of the forms described as leucoplakia and icthyosis glossæ, of which Mr. Jacobson makes so much in his paper on the precancerous conditions of the tongue. Perform a simple experiment for yourself. Breathe a mouthful of cigarette smoke through a clean handkerchief, or blow a jet of smoke from your pipe stem through it, and you will get ocular demonstration of the injurious accompaniments of the soothing influence which we derive from the sociable weed. At the same time, I do not say that every inveterate smoker is predestined to a horrible death, nor do I think that a total abstainer from tobacco and spirits is exempt; my list includes three such exemplary persons who still fell victims to this scourge. I think, however, you will admit that, given a cancerous diathesis, if such there be, given an initial injury to the tongue, the constant application of tobacco smoke, by aggravating the result of injury, and so producing a chronic sore, is more likely than not to induce epithelioma when that time of life arrives at which the tissues are degenerating. It would be interesting to know if the steady increase of death from cancer, as shown in the Registrar-General's returns for 1851 and 1879, together with the steady rise of the proportion of tongue cancer from 2·6 to 11·5 of all cancers, bears any relation to the increased revenue from the tobacco excise.

I think the question of tobacco may, in a measure, explain the preponderance of male over female cases, notwithstanding my previous quotation with regard to the pipe-smoking ladies of Finisterre. It is difficult to

get good statistics from the Eastern harems as to the prevalence of epithelioma among their devotees to St. Nicotine, but, if there be anything in it, the progress of the emancipation of women should entitle them to another of man's burdens.

As to teeth, I regard them as much or more to blame than tobacco, for they must in many cases be the initial source of injury and infection. Think of the ghastly "dentures," to use the more refined term, though not in its true technical sense, which one meets with among the out-patients. Imagine the result of years of contact of such with a fairly delicate organ like the tongue! Here, again, I think there may be a reason for the comparative immunity of women. They have more consideration for their appearance and comfort, and instead of carrying about a foul and jagged stump in their jaw for years, they flock in their hundreds to the dental out-patients, and appreciate the benefits of the conservation room.

It is difficult to glean much as to the result of spirit drinking. Of my list of cases twelve yielded to the importunities of the ward clerk, and admitted to "now and then taking some, but nothing out of the ordinary," only our candid opium-eating friend had the courage to attribute his disease to a predeliction for ardent, undiluted spirits.

I thought that perhaps the site of the initial injury might give us some information as to the result of pipe-smoking. One is accustomed to smoke either on one side or the other almost exclusively; I had expected the right to be the favorite pipe position, but find no preponderance of cases originating on the right side, in fact, of the 95 cases the left side heads the list with 45, while the right is represented by 35. Mr. Barker finds the right side more frequently affected than the left, but the difference is very slight being 21 to 18 out of 39 cases. I think, then, that "side," whether right or left, does not count for much, especially as since I have begun this work I have tried to determine a ratio of right to left-sided smokers as one sees them in the street, and have come to the conclusion that the honours are easy. I think the position, as regards tongue surface, is one of importance, and, as one would expect from the influence attributed to the teeth, the majority of cases are first detected at the margins; my list works out as follows:—

Right upper surface	11
Left ,, ,, ...	12
Right margin	24
Left ,, ...	33
Under surface	8
Dorsum	3
Tip	3
Frænal tissues	1
Total	95

showing that the margins are first affected in 60 per cent. of the cases, while in only 6 per cent. was the initial lesion strictly in the median position. In fact, Bland Sutton, while admitting a fair proportion beginning on the dorsum, says such are always distinctly to one side or the other: he adds that the beginning of the disease is always at some spot in the anterior 2/3 of the tongue, a statement which is not altogether borne out by my list, for three patients described their first symptoms as pain in the root of the tongue on deglutition. This may be due, however, to the fact that the onset of the disease is peculiarly insidious and painless many patients declaring that there is no pain present, some being absolutely ignorant of the lesion when it has occurred in more than one place, in fact it is not until the deeper structures of the tongue are invaded that there appears "the incessant weary aching of tongue, ear, face, and teeth; lit up into flashes of positive agony by a touch, by uttering a word, or by swallowing," as Mr. Jacobson so graphically describes the awful pain of the later stages of this terrible disease.

(To be continued.)

Pass List.

University of Cambridge, Easter Term, 1900.

THIRD EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

PART I.—J. M. Brydone, H. N. Clarke, J. S. Steele-Perkins, E. W. S. Rowland.

PART II.—T. E. Holmes, F. J. Nicholls, J. G. Taylor.

Final Conjoint Examination, April, 1900.

MEDICINE, SURGERY AND MIDWIFERY.—*E. A. Miller.

MEDICINE AND MIDWIFERY. *R. C. Mullins.

SURGERY AND MIDWIFERY.—J. M. Brydone, A. W. Talbot, T. P. Thomas, T. J. Wright.

MEDICINE ONLY.—*J. B. C. Brockwell, *E. Cohen, E. I. Davis, E. H. Felton, *H. W. Fox, *E. W. Goble.

SURGERY ONLY.—*H. B. Dismorr, *C. Edwards, D. Forsyth, *L. C. Martin, H. McD. Parrott.

MIDWIFERY ONLY.—E. G. Andrew, F. G. Cross, K. W. Goadby, E. T. Jensen, T. Morgan, J. S. S. Perkins, E. F. Reeve, E. Shelton-Jones, W. M. Thomas, R. Tilbury, F. E. Wilson.

* Denotes completion of examination.

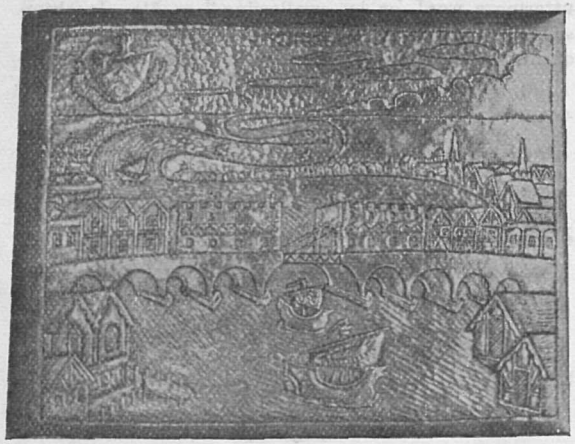
Notice.

MICHAEL HARRIS PRIZE IN ANATOMY, 1900.

THE above Prize has been awarded to Mr. A. M. Webber, a Certificate to Mr. R. Larkin, and equal Certificates to Messrs. W. L. M. Day and L. H. Moiser.

The Illuminated Address to the late Mr. Davies-Colley.

HEREWITH we reproduce three photographs of the above address, which will be of interest, although, of course, they convey only the faintest idea of the original. The first shows the cover, which is cased in hammered copper, bearing a repoussé design of a conventional old London



Bridge. The second shows the first page with an illuminated figure of Fame, and the text of the Address. The third photograph shows two pages of signatures reproduced in facsimile.

Mr. Davies-Colley was deeply touched by the spirit which had prompted the Address, and dictated the following letter to the signatories of the Address:—

My Dear Friends of Guy's Hospital, Colleagues, Past and Present Students,—I thank you all for the splendid memorial, and far too flattering appreciation of my services in the school and wards of the hospital, which I have just received from you.

It has been a very great grief to me to leave you all so suddenly. But if anything could relieve that grief it is the reflection that the efforts which I have made to do my duty among you have met with so cordial a recognition upon your part.

I desire also to express my admiration for the beauty of the design and its artistic decoration. I have no doubt that the book will be kept as an heirloom and most prized possession by the members of my family.

And now it remains for me to say farewell to all. May God's blessing rest upon you and upon the dear old school and hospital.

With feelings of the deepest love and affection for you all,—I remain, most gratefully yours,

Borough, Pulborough, May 4th, 1900. N. DAVIES-COLLEY.

Passim.

It was only a few months ago that we recorded with regret that ill-health had necessitated the retirement of Mr. Davies-Colley from active work at this hospital. To us now falls the intensely painful duty of chronicling his lamented death. Although the gravity of his illness was well known at the hospital, the suddenness of the end struck us with stunning force, and we found it hard to realize that the man whom we had all loved and respected was no longer in this life. Of his attainments as a scholar and his skill as a surgeon it is not ours to speak, but of his kindly patience in his relation to us as students, and of his almost womanly tenderness in his consideration for his patients, we shall always bear vivid and affectionate remembrance. By his death the hospital has lost a great and noble son, and we, as students, have lost a very dear friend. The deep and heartfelt sympathy of all who were privileged to know him, whether as a colleague or as a teacher, will be extended to his family in their crushing bereavement.

We have received an advance copy of the Annual Report of the Governors of Guy's Hospital for the year 1899. The general arrangement of contents is too well known to our readers to call for any comment here. There are, however, one or two points which may well be emphasized. Primarily comes the fact that of the five hundred thousand pounds necessary for the establishment of this Charity on a sound financial basis, a little over half is as yet unsubscribed. The needs of the moment doubtless cause much of the money which would otherwise replenish our coffers to flow into other channels. It is hardly to be expected that the immense sums which have been raised of late in connection with the War, the Indian Famine, and the rest, should not materially affect the finances of large general hospitals such as ours. Still, among those immediately connected with Guy's Hospital the fact should not be forgotten that the work of re-endowment is only half completed, and that our claims on the purses of the charitable are still of great moment. Another point in the report is the magnitude of the total expenditure for the year. But an analysis of this account shows that the great increase in disbursements is due almost entirely to the extensive building operations which were so very necessary, both in the repair of the old buildings and in the construction of new laundry houses.

Guy's House is nearly two hundred years old, and the long years are beginning to tell on the eighteenth century brickwork. Moreover, surgery and nursing have made some little advancement since the days of Thomas Guy, and the addition of the now absolutely indispenable sanitary blocks to the wards has revealed the general state of decay into which the old building was drifting. The provision of the laundry, too, has been for some time inadequate, and, indeed, it becomes a matter of wonderment that the work could ever have been properly conducted in such cramped quarters. Thus the increased expenditure, so far from pointing to any relaxation of the methods of rigid economy, is, in reality, in strict accordance with its best principles. Finally, there will be noticed a change in the cover of the report, and although such a change is of trivial importance, it is a distinct gain to the appearance of the book.

Curiously enough, the report of the youngest "general" hospital, the Imperial Yeomanry, was received almost at the same time as that of our own hospital It tells the tale of the inception of the idea, the appeal to the public and the very generous response. The committee admits that the subscriptions received were far in advance of the most sanguine expectations, and, thanks to the generosity of the charitable public, sufficient to make the hospital the most complete of its kind. There are two little things in the report itself to which we must take exception. Possibly out of compliment to the well-known views of the German Emperor the report opens with the following poetic words:—"*Towards the close of the last century*, when the din of battle rent the air in South Africa, intelligence reached our shores that, against overwhelming odds," etc. The italics are our own. Surely, it is unwise to preach a heresy of the calendar in a business statement of affairs. The other point is in connection with the list of medical officers. It is quite unnecessary and at variance with custom to label a man "Dr. Jones, M.D., M.B. Lond., F.R.C.S., M.R.C.S., L.R.C.P."! And yet the same peppering with letters occurs time and again. However, despite one or two little vagaries of this nature, the report shows a condition of things of which any committee might well be proud.

On another page will be found accounts of some interesting cases that have occurred quite recently in the Lying-In Charity. Doubtless, there are many Guy's men in practice to whom these cases will recall others of their own experience bearing some relation of similarity, or striking dissimilarity. We should be glad, therefore, to receive comments and suggestions on these cases, both from the point of view of hospital and private practice.

A correspondent "A. C. C." sends us the following cutting. He neglects, however, to add the name of the journal from which it is taken. We are, therefore, unable to make the usual acknowledgments, and trust that the unknown journal will accept our apologies for remissness in this respect.

Microbes have been found in Ice—

We have boiled the hydrant-water,
We have sterilised the milk,
We have strained the prowling microbe
Through the finest kind of silk.
We have bought and we have borrowed
Every patent health-device,
And at last the doctor tells us
That we've got to boil the ice.

The first number of the *Devil's Fountain, or the Dee'lfontein Gazette*, the journal of the Imperial Yeomanry Hospital, has just come to hand. Mr. Newland-Pedley, who is apparently the handy man of the hospital, appears in a new rôle, and shares with Colonel Sloggett, the "Press Censor," the dignity of the front page. We must congratulate him on his bright little paper, and on the lofty aims and modest language of the first editorial. The journal is "destined to record the history of the greatest civilian hospital, and the most numerous and most brilliant staff that ever left the shores of any country." Also, "Truth and honesty will be the guiding stars of the *Gazette*, and to save disappointment it should at once be mentioned that all the abuses connected with journalism elsewhere will be strictly avoided in the *Devil's Fountain*. . . . Any statement that cannot be verified will be marked with an asterisk."

The journal consists of eight foolscap pages of type-written matter, chiefly of a light nature, generally personal, and by no means devoid of humour. A cutting from the *Sporting Times* proves that the hospital is not altogether separated from the outside world. One little paragraph in the *Devil's Fountain* under the comprehensive title "Music" is worth repeating:—"A camp absolutely devoid of music is a dull place, and after our first week Mr. A. C. Ransford made a determined effort to cheer up his friends. It was the day we moved our camp, and all ten dressers were domiciled in one large tent. The light of two candles made the surroundings more gloomy than before, but Mr. Ransford produced a tin whistle, and lying full length on his bed, gave a recital of all the tunes he knew or used to know; these included the 'Dead March in Saul.'" However, the arrival of a piano from Cape Town allowed a little more freedom to musical talent, and we are promised an account of a grand concert in the next number.

What might have proved a really serious fire occurred last Saturday at the hospital. By some means or other, unknown, portions of the stores which are situated beneath the hospital library caught fire. About a quarter to eight in the evening, the alarm was raised by a ward-maid, and at once the private hose was brought to bear on the flames. The brigade, consisting of one assistant house-surgeon, an extern, and a bathman, with great promptitude poured immense volumes of water over the flames, and incidentally over each other, and in a short time the fire was out. Then the Salvage Corps men came on the scene and removed the water in buckets, to the disgust of the regular firemen, who had meanwhile arrived with two engines and were prepared to flood the whole hospital. So the whole affair ended in smoke—and water, but all the same, it would be unfair to deny that but for the prompt action of Judge, the bathman, and his ready followers, an ugly fire might have resulted, with possible disaster.

Now that the lawn tennis season has commenced, it will be as well to call attention, once and for all, to a matter which gave rise to considerable annoyance last year, although the matter in itself was trivial enough. We refer to the unnecessary and uncleanly habit of playing tennis unchanged. It should surely be superfluous to call anybody's attention to the additional comforts which may be obtained by changing into flannels for all kinds of exercise. Were the benefits merely personal, we should have no business in the matter; but it is on behalf of the men who play according to the civilised code that objection is raised to this practice. Men in shirt-sleeves in a hot sun do not present a picturesque appearance on the ground, and their presence afterwards in the

club-room, more especially at tea, does not add to the comfort and delight of the majority. We hope that this slight protest will be sufficient to remove the source of complaint. Should, however, men still persist in offending, the Lawn Tennis Club is prepared to take steps, in the interests of its members, to render all such practices illegal, and punishable as such.

The funeral of the late Mr. Davies-Colley took place at Pulborough last Thursday. Wreaths were sent by the Residents, the Football Clubs, of which Mr. Colley was president for many years, the Dental School and the Medical School. In our next issue we shall publish a special photograph of Mr. Davies-Colley, produced in a precisely similar manner to that adopted in the photograph of Dr. Pye-Smith. There will be, in addition, an obituary notice from the pen of Mr. Charters Symonds, whose position as corresponding Assistant-Surgeon makes the tribute the more fitting.

Nursing News.

Matron's Office.

On Tuesday, May 1st, Miss Ellen Kate Finnemore commenced her duties as Probationary Sister in Martha ward.

On April 30th, Nurse Pegler, Head Nurse in the Isolation ward was transferred to Martha ward, and Probationer Oldham was, on May 5th, appointed Head Nurse in the Isolation ward.

On April 30th, Probationer Lamb was appointed Head Nurse in the Out-patient department.

On May 1st, Nurse E. Davies, Head Nurse in Mary ward, who entered the Hospital four years ago, left to take up work in a surgical home, and Probationer Park was appointed Head Nurse in Mary ward in her place.

On May 3rd, Nurse Knox, Head Nurse in Mary ward left the Hospital at the end of her three years' training, and Probationer Mudge was appointed to succeed her as Head Nurse in Mary ward.

Acknowledgements.—Clinical Journal (2), Hospital (2), Medical Temperance Review, St. Bartholomew's Hospital Journal, Journal of Balneology.

The *Graphic* for the week ending May 5th contains an admirable photograph of the Medical Staff of the Hospital Ship *Maine*.

From the Charity.

The following are some notes on a few of the more interesting cases that have occurred in the Hospital Lying-in Charity during the past two months:—

Case I.—*Ante-partum hæmorrhage.—Shoulder presentation.—Total separation of placenta.*—E. C., æt. 31. Patient had had six previous children at term, three of which were still-born. All were difficult labours, the children, patient says, all coming "feet first." March 2nd. Labour commenced in the early morning, and the membranes ruptured early. Extern was sent for at 5 p.m. on account of a severe flooding, during which quite a pint and a half of blood was lost. Pulse 110 per minute, small and very easily compressible. On examination, the os was found well dilated, with the right shoulder and arm presenting. Abdominal examination showed the head in the right iliac fossa, and the abdomen of the child looking downwards and forwards The fœtal heart could not be heard. Patient was removed to hospital, where A.C.E. mixture was administered, and, as the head could not be easily brought into pelvis, internal version was performed, the left leg being brought down. During the operation no pulsation could be felt in the cord, and the placenta was found to be lying quite free in the uterine cavity, having been completely separated. The child was born by uterine action in twenty minutes, followed immediately by the placenta. The child had evidently been dead for some hours, but there was nothing in the appearance of the placenta to account for this early separation, neither was any history of accident, etc., obtainable. The mother lost a good deal of blood, but made an uninterrupted recovery.

Case II.—*Central placenta prævia.—Perforation of placenta.—Bipolar version.*—M. M., æt. 35. Patient had seven previous normal labours. March 14th. Patient said she had not felt well throughout this pregnancy. Six weeks ago she had a "flooding," since when she has remained in bed. This afternoon she had more bleeding, losing in all about ten ounces. On examination, the internal os just admitted the tip of the index finger, when placental tissue was reached; no membranes could be felt. By the abdomen the fœtal head could be felt in the right iliac fossa and the breech in the left. Active movements were going on, and the fœtal heart could be heard just below the umbilicus. Patient calculated that she was seven months advanced in pregnancy. The cervix and vagina was plugged with sterilised lint, and the patient removed to the hospital. A.C.E. mixture was given, and the os easily dilated with the fingers. No membranes could be reached by the finger in any quadrant of the lower uterine zone. The placenta was accordingly perforated and bipolar version performed, a half breech being brought down. The body of the fœtus came down easily, but considerable difficulty was experienced when the head, surrounded by placental tissue, became jammed in the cervical

canal. The surrounding placenta was pushed up over the head, and a seven months' child born dead. The placenta was soon expressed, and found to be thin and of large area, the seat of perforation being in close proximity to the attachment of the funis. The mother made a good recovery.

CASE III.—*Concealed accidental hæmorrhage.—Eight months pregnancy.*—M. T., æt. 42. Patient had ten previous normal pregnancies at full term and one miscarriage at the sixth month. March 16th. Whilst patient was at her work she was suddenly seized with abdominal pain and faintness. She immediately vomited, and owing to the continuance of her pain, was obliged to go to bed. A local practitioner was called, but refused to have anything to do with the case, sending a messenger for the Charity. When seen about three hours after the onset of the pain, the patient was in a very collapsed condition, pulse 120, small and running, face pale and drawn, eyes sunken with small pupils, and the body covered with cold clammy sweat. She had vomited several times, and complained of general abdominal pain. The uterus reached to within an inch of the ensiform cartilage (pregnancy—eight months), was extremely tense and painful to the touch. The abdominal wall was flaccid and could be readily moved over the uterus. On examination there was a slight blood-stained discharge in the vagina. The os was about the size of a florin, the membranes being unruptured and tense. Intra-uterine hæmorrhage was diagnosed and the membranes ruptured, the liquor ammii being slightly blood-stained. Patient was given some hot tea and removed to the hospital. No fœtal movements had been felt since March 14th, two days previously. On admission patient was extremely collapsed, pulse 140, very small, drowsy, sweating, and very pale. She was given more hot drinks and her condition improved somewhat. The os was dilated by the fingers and manipulated over the head. Slight uterine pains came on, and as there were no signs of further hæmorrhage, the labour was allowed to proceed without instrumental assistance. The child was born in two hours, followed by the placenta which came down in the shape of an inverted umbrella—it was pale, and attached to its uterine surface was a large clot, which weighed, when removed from the placenta, 1¾ pounds. There was no post-partum hæmorrhage. The child had been dead some time. The patient steadily improved, although the pulse remained above 100 during the next forty-eight hours, and she left the hospital on the sixteenth day after delivery. We consider this case of especial interest, as in Dr. Galabin's statistics of 49,145 cases in the Guy's Charity, only *one* case of concealed accidental hæmorrhage is recorded, whilst in a collection of cases elsewhere, the maternal mortality exceeded fifty per cent.

CASE IV.—*Mixed carneous and hydatidiform molar pregnancy.* A. H., æt. 30. Five previous normal labours. One miscarriage at fourth month. The last period occurred at end of May, 1899, and during the next four months patient had all signs of pregnancy—morning sickness, enlargement of the breasts, etc. After this, however, the latter began to decrease in size, and in September last patient passed a small amount of blood per vaginam. On several occasions since this she noticed a slight brownish discharge, and as she "did not get any bigger," she came up to out-patients, where no definite diagnosis was arrived at. Some few days after this, on March 24th, patient had a few pains and, with a small quantity of blood, passed a firm, fleshy mass. This was of a flattened, pyriform shape, measuring three and a half inches in its long axis, two inches in width at the broad end, and about one inch in thickness. The broader end and the whole of one surface of the mass appeared to be made up of firm placenta tissue, but on the other surface the remains of the amnial cavity were found. On dividing the thickened membranes to open up this cavity, no liquor ammii was found, neither was there any trace of the embryo, the great part being filled with raised bosses projecting into the cavity and pushing the membranes in front of them, which proved on section to be formed of blood-clot in various stages of decolorisation. On a longitudinal section being made of the mass, the greater portion was formed of organizing blood-clot—mostly old, but in one part more recent—contained in meshes of firm placental tissue. In the upper broad end of the mass, the tissues were less dense and contained an area in which hydatidiform degeneration had taken place, numerous small vesicles averaging about two to three mm. in diameter being present. There were no vesicles present on the surface of the mass and nothing to indicate their presence until a section had been made. The patient made an excellent recovery, her temperature never rising above 99·4° F.

CASE V.—*Abortion at six and a half months. Fœtus contained in unruptured membranes with attached placenta expelled simultaneously.*—C. M., æt. 23. One full-term dead child born in June, 1899. In the July and August of that year normal periods came on, but since then patient has seen nothing until April 2nd, when she had a "show." Real labour pains came on on April 4th, and when seen on that day the os was fully dilated, with membranes bulging into vagina; a hand could be felt at side of head. No fœtal heart or uterine souffle could be heard. In a very short time the strong uterine pains expelled the fœtus enclosed in the unruptured bag of membranes, with a small placenta firmly attached to the outer surface of these latter, en masse. There was no inversion of the uterus. Patient had never felt any fœtal movements. The fœtus was evidently between six and seven months, the finger nails forming and the external auricle measuring nineteen millimetres. The mother made a good recovery.

CASE VI.—*Eclampsia during labour—forceps delivery* April 7th. S. P., æt. 22, primipara. Patient had a doubtful history of epileptic or hysterical fits in the past two years. Epilepsy in several brothers and sisters. Last period, middle of July, 1899. No œdema, headache or twitchings previous to labour. Pains commenced April 6th, mid-day; at 11 p.m. pains sharp and frequent; os, half-a-crown; membranes ruptured; presentation R.O.P.

Pains gradually got weaker and less frequent. At 3 a.m., April 7th, head was high up in pelvis; patient had a slight pain which brought on a typical epileptiform seizure lasting one and a half minutes. There was a short stage of tonic spasm, followed by clonic convulsions; there was no cry; the tongue was bitten. She quickly recovered from this and slept well, the pains having quite left her till 4.30 a.m., when she had a similar fit, whether initiated by a pain is uncertain. The fits recurred with increasing frequency till 8.30 a.m., the patient becoming almost comatose in the intervals. She had had up to now eight fits in all; her pulse was under 100; no pains and consequently no advance of head; quite unconscious. Fœtal heart was heard. Patient then had two severe fits in twenty minutes; her pulse rose to 120, and became very much feebler; her respirations were shallow and features dusky. She was removed to hospital, and on arrival her pulse and colour were a little improved, and she had partially regained consciousness. A catheter specimen showed the urine to contain a large quantity of albumen. Forceps delivery was determined on. She had another fit at 10 a.m. Chloroform was given. The os was 4/5 dilated; head half way down pelvis. Axis-traction forceps were applied. The head was brought to the perineum, when no rotation of the occiput forwards having taken place, the forceps were removed and ordinary ones applied, and delivery completed. Several convulsive attacks occurred during the operations. The placenta was adherent and had to be digitally removed, only slight hæmorrhage followed. Ergotinin was injected, the uterus contracting down well. As the patient's condition was bad, pulse 140, a pint of normal saline was infused into each breast, and a pint injected rectally; slight superficial rupture of perineum occurred.

The child was very asphyxiated, and after prolonged efforts respiration was initiated by the tongue-pulling method. It was full term and normal size and weight.

The next day the albumen had greatly diminished; urea 2·4 per cent.; sp. gr. 1022; eyes normal. Albumen progressively diminished, and patient left the hospital on April 30th, with albumen merely a trace—after a normal puerperium. Child doing well.

CASE VII.—*Cæsarian section for contracted pelvis.* E. Y., æt. 37, admitted April 8th, in labour. Patient was a multipara, and had had the following pregnancies:—

1. Full term; still-born, without instruments.
2. Miscarriage at third month.
3. Full term; version performed; still-born.
4. Living child, with instruments. Now æt. 2½ years.
5. Face; cephalotripsy; difficult delivery.

She attended Out-patients on March 29th, and was advised to come into the hospital when labour should commence, for Cæsarian section. On admission, patient was in labour, having good pains. The fœtal heart was heard a little to the left of the umbilicus; the head was felt under the ensiform cartilage. An œdematous congested mass, about the size of a Tangerine orange, was found to be protruding beyond the vulva. This on further investigation proved to be the very œdematous anterior lip of the cervix. The os was fully dilated, membranes bulging into vagina; no presentation felt. A.C.E. was administered, and Dr. Horrocks made an incision through the abdominal wall about six inches long. The uterus was found to be rotated somewhat to the right; the placenta was behind. The child was delivered alive within three minutes of the commencement of the operation. It weighed nine pounds. There was scarcely any hæmorrhage. Patient was sterilized by resection of about an inch from each Fallopian tube. The entire operation occupied twenty-five minutes. The mother made a perfect recovery, and the child is doing well. Length of scar (April 30th), four inches. Measurements, March 30th.—Interspinous (outside) 8½ inches (inside) 7½ inches; intercristal, 8½ inches; external conjugate, 7 inches; diagonal conjugate, 3½ inches; distance between posterior superior iliac spines, 4 inches. No evidence of rickets or curved bones.

CASE VIII.—*Pulmonary thrombosis following labour.*—Death. April 8th. E. D., æt. 24. Multipara. Two previous pregnancies; full term; normal. No history of rheumatism or phthisis. Had been quite well until present pregnancy, during which she had lost flesh somewhat, and had had a slight cough. No hæmoptysis. Some varicose veins on legs during the pregnancy. Some slight thrombosis in a few small veins over right anterior tibial region. No œdema. Patient was fairly well nourished, good colour, somewhat fragile in appearance Last period some time in August; since then no loss of any kind. For a fortnight previous to labour had had some sweating and slightly more cough.

April 8th. Case first seen by extern 12.15 a.m. No show; os a shilling; presentation vertex; no labour pains. Complained of feeling feverish; pains in back of head and limbs. T. 102°, P. 120, R. not particularly hurried.

9th. T. 102·6°, P. 120; no physical signs in heart or lungs. Mist. Quininæ ℥j. 4tis. horis. R.O.P. presentation diagnosed.

10th. Child born before arrival of extern. Placenta and membranes entire. No vaginal examination made; full term child; alive. Hysterical attack just before labour. T. 100·2°; generally much better.

11th. T. 99·4°, P. 96; very much better.

12th. T. 101·6°, P. 112; plenty of milk; lochia normal.

13th. T. 99°, P. 100.

14th. T. 99.6°, P. 108.

16th. T. 98·4°, P. 80.

19th. Patient feeling quite well; lochia normal and pale.

20th. Patient got up in evening for two hours; felt quite well.

21st. Patient got up in morning, but was shortly afterwards seized with a sudden attack of dyspnœa and pain in right chest; mid-day: T. 98·4°, P. 144, R. 36; evening: T. 96·6°, P. 144, R. 44. The pulse was dicrotic; there was a well marked triple rhythm audible all over

the præcordia; no bruits or rub. Slightly impaired note at right base below eighth rib, and entry not quite so good as at other base. Patient had some difficulty in spitting up a little frothy mucus. Abdomen and uterus normal; complete rest enjoined; fluid diet: Mist. Scillæ Ammoniata ʒj, 6tis horis.

22nd (evening). *Much better; pain almost gone from chest*; signs at base cleared up. T. 98°, P. 120, R. 42.

23rd. T. 100°, P. 120, R. 36, improving.

24th. In the morning patient was seized with another sudden attack of dyspnœa, with pain at right side of sternum. This was quite independent of exertion. T. 100°, P. 164, R. 60; (evening) T. 102°, P. 160–170, R. 64. Triple cardiac rhythm still well marked; no bruits. Impulse in normal situation; pulse very dicrotic. Impaired note over whole of right chest behind, with some diminution in loudness of breath-sounds on that side; there was no abdominal pain whatever. Lochia very slight, pale, quite sweet. Uterus was freely movable, not tender, and appeared to be involuting normally. Nothing felt in either fornix. There was a split on the right side of the os. Patient was ordered Tr. Digitalis mviii., Mist. Ammoniæ ad ʒj., 6tis horis, Brandy ʒss. 2dis horis.

25th. Patient better; pain less. T. 98·6°, P. 160, R. 45, scarcely any difference in note and air entry to be made out between two sides; (evening) T. 100·2°, P. 126, R. 40; more comfortable.

26th. A slight attack of dyspnœa in the morning; T. 98·8°, P. 120, R. 40; comfortable.

27th. *Very much better.*

28th (morning). Felt quite well; T. 98·4°, P. 80. At about 11 p.m. patient was quite suddenly, and independently of any exertion, seized with an attack of extreme dyspnœa, with severe pain over the front of the chest. On arriving at the house, she was found almost unable to speak, her colour was a little full, but she was not cyanosed; T. 99·6°, P. 144, R. 68. Her condition was *too bad to allow of any physical examination.*

29th. At 3 a.m. she was seized with more urgent dyspnœa and a convulsive attack, and died in a few minutes. Permission for a partial post-mortem examination was obtained with much difficulty, and on

April 30th, at 11 a.m., the thoracic viscera were examined. The heart was relaxed and its cavities empty, except the right ventricle, which contained a cylindrical ante-mortem clot about two and a half inches long by half an inch cross section. More recent clot extended from it through the auriculo-ventricular valve into the right auricle. That in the ventricle when cut across showed well-marked lamination and was breaking down slightly in the centre. Valves normal. *Lungs.*—The right lung was dark in colour, very much tougher than the left lung and only slightly crepitant. Small pieces only just floated in water. *There was slight recent pleurisy* over the base. The right pulmonary artery was plugged with ante-mortem clot, which extended down several of its main branches for distances of from one to five inches. The clot was partly decolorised, slightly adherent to the vessel wall in several places and laminated on cross-section. At the distal extremities no appearances definitely suggestive of emboli plugging the smaller branches could be found. The left lung had patches of local emphysema, especially at the apex of the upper lobe. *It was otherwise normal. In the main* branch of the left pulmonary artery was a clot extending for a very short distance down some of the smaller vessels. This clot was soft, not adherent, showed no lamination and was hardly at all decolorised, and was not definitely ante-mortem.

The interest of the case lies in the difficulty in determining whether this was a case of primary pulmonary thrombosis, or primary cardiac thrombosis with secondary pulmonary emboli; or whether the whole thing was embolic, from clots in the uterine veins, or from the slight phlebitis (quite unnoticed by patient) in the tibial veins. The only discoverable source of sepsis was the slight tear in the cervix. The suddenness of the attack certainly suggests embolism as being the primary cause, and it is noteworthy that only the first seizure followed any exertion. Other prominent features were the very rapid, feeble pulse in every attack, and the irregular pyrexia accompanying them. It also illustrates the grave prognosis in these cases which have recurrent attacks, as on the day of the last seizure patient looked and felt so well that her friends were incredulous when the possible issue was held before them. The treatment throughout was simply absolute rest, stimulants, as brandy and ammonium carbonate, and liquid food in frequent small quantities.

(We are indebted for many of the above facts to the notes kept by the extern to the case, Mr. T. H. B. Dobson.)

Case IX.—*Flat pelvis, with some oblique contraction.* —April 17th.—S. J., æt. 27. Multipara, four pregnancies previously, all born alive. Instruments with first. All the labours had been very protracted. Labour had commenced at 11 p.m. the previous evening. The membranes ruptured shortly after, and pains were feeble and infrequent. At 4.0 p.m. on the day of admission abdominal examination showed the fœtus to be presenting by the vertex which had not entered the brim, with the back to the left and anterior. Vaginal examination showed the head to be firmly fixed in the brim, with the greatest diameter above it. The cervix was about 4/5 dilated, soft and imperfectly retracted over head. The right ear could be easily reached. Head well flexed. There was a fairly large caput. The sacral promontory was felt with great ease, and there appeared to be slight general contraction. There was no advance with pains, which, however, were few and feeble. Patient refused further interference or admission to the hospital. 10.0 p.m. No advance, although pains had been strong and frequent. *Caput very considerable*; slight œdema of the vagina. Patient a good deal exhausted. She was removed to the hospital. Here it was ascertained that there was some oblique contraction of the right side of the pelvis as well

as the flattening previously observed. There was considerable Nægele-obliquity of the head, what was afterwards ascertained to be the right posterior temporal fontanelle being felt under the pubes. Axis-traction forceps were applied under an anæsthetic, and after about half an hour's pulling the head was delivered. The blades gripped the face and occipital region. The head was greatly compressed and there was a well-marked dent on the left side of the head caused by the promontory; there was a very large caput over the right parietal bone. The child weighed 10½ lbs. Diagonal conjugate 3¾ inches. There was considerable p.p.h., and the pulse rate reached 150. The uterus eventually contracted down well. The child had a series of convulsive attacks and died in about twenty-four hours There was a well-marked depression on the right parietal bone where it had been flattened against the pubic arch, and considerable meningeal hæmorrhage over the whole of the vertex.

CASE X. — *Total placenta prævia. — Uterus torn in delivery.—Death.*—April 8th. J. B., æt. 24. Multipara. Admitted for ante-partum hæmorrhage. Two previous pregnancies—quite normal. On April 14th patient came up to the front surgery, having that morning had a not very severe flooding. She had had no previous loss. Date of last period uncertain, but she believed herself to be about seven and a half months advanced. A vaginal examination was made, and the os was found to be high up and barely admitting the tip of the finger. Her pulse and colour were good. The flooding had not followed any blow or exertion, but had occurred while in bed and asleep. She was given some opium and ordered to go home and stop in bed, and send up if further hæmorrhage occurred. At 5 a.m. on the morning of the 18th, again while in bed, another severe flooding came on, and assistance was sent for, when it had stopped. She had no pains. When first seen at 8 a.m., patient was distinctly anæmic, and her pulse was rapid. By abdominal palpation the fœtus appeared to be lying somewhat transversely. The fœtal heart was heard. Per vaginam the os admitted two fingers, and nothing but placenta could be felt. She was immediately removed to the hospital. At 11 a.m., hæmorrhage recommenced, and it was decided to bring on labour. The placenta was separated as much as possible round the os (it was almost centrally placed), and after some difficulty the membranes were reached, perforated, and a foot brought down. But with this the placenta was immediately expelled into the vagina, the patient having lost a good deal up to this stage of the proceedings. The os dilated without much difficulty to allow the passage of the breech and body, but tightly gripped the head, the arms being extended. Patient's condition was now rather bad; she was more anæmic, pulse rapid, and she was a good deal exhausted, but her condition still not grave enough for anxiety. The cervix proved to be very rigid. With great difficulty the arms were brought down, but the head was unable to pass, although traction was maintained during the pains. After some time, as patient's condition was getting worse, it was decided to perforate, and this was attempted with a pair of sharp-pointed scissors. This instrument proving inadequate, while another was being prepared traction was made in the next pain, and the head suddenly came through the os. Copious hæmorrhage followed, some of which was certainly arterial, but no spirting vessel could be felt, and it was found that the cervix had split deeply on the left side. The uterus did not very readily contract, but by bimanual compression, hot douching and subcutaneous injection of citrate of ergotinin, it was made to do so quite firmly. Patient was now very blanched, and her pulse running and very rapid. About three pints of saline solution were infused under the breasts, and her condition improved by 2 p.m. About 2.45 she was noticed to be getting still paler and her pulse worse, and was found to be still losing. The uterus was fairly well contracted. More ergotinin was injected, and several pints of saline injected intravenously and under the breasts. The bleeding was thought to come from the ruptured cervix, and the vagina was accordingly plugged. The uterus now began to relax, and her condition was critical. It was determined to plug both uterus and vagina tightly, and keep the fundus digitally compressed. This was done as rapidly as possible, but was scarcely completed before the gauze was soaked to the vulva, and the uterus was felt to be quite relaxed. Time, 3.30 p.m. The plugging was removed and the uterus compressed bimanually and the hottest of douches again tried, but proved unavailing. Bimanual compression was maintained till the end, but the uterus remained completely relaxed, and patient slowly collapsed and died at 4.45 p.m. The loss for the two hours preceding death had been comparatively slight, but continuous, but following on her previous anæmic exhausted condition, was sufficient to determine a fatal result. At the post-mortem a tear was found on the left side, extending upwards from the cervico-vaginal junction into the uterus, opposite the left broad ligament attachment, for about three inches. There was a small hæmatoma of the cellular tissue of the broad ligament. There was also a slight superficial tear, not involving the muscular tissue, on the right side of the os, about an inch and a half long.

CASE XI.—*Brow presentation, with large meningocele.* April 28th. H. T. Multipara. Labour pains commenced at 3 a.m., membranes ruptured 12 noon, first seen 1.30 p.m. Head was then engaging pelvis and presenting in the brow position with much lateral obliquity, so that the left eye and ear could be readily felt. Pains strong and frequent. The head descended in this position till it was on the perineum, when the chin rotated under the pubic arch. Some delay then occurred, when the head was eventually expelled, followed by the meningocele. There was some hæmorrhage, and several pieces of placenta had to be digitally removed. The child was eight months. The vertex sloped straight back from orbital arch. The tumour, which was almost as large as the head itself, was pear shaped and attached to the back of skull over occipital bone. It measured five

inches antero-posteriorly and eleven inches in circumference. Child died in three days, and post-mortem the tumour was found to contain a large quantity of brain matter.

Case XII.—*Hand and foot presentation: bipolar version. Hour-glass condition of uterus — adherent placenta.*—A. A., æt. 29. Multipara—first child at full-term, the second at seven months, when the placenta was adherent and had to be digitally removed. After eleven days she had a "flooding," and was curetted, but was laid up for about six weeks. The husband is an old naval man, and there is a suspicious history of syphilis. April 29th. Labour started at 11 a.m., and when seen at 5 p.m. the membranes were bulging in vagina. They quickly burst. The os was found about three shillings, with thick edges, and the left hand presenting. At 6.30 p.m patient was having slight pains and the left hand and right foot were found presenting at the os. On abdominal palpation, the fœtal head was found in the right iliac fossa, the breech in the left, the back of the child being arched across the uterine fundus, and the ventral surface looking downwards and forwards. The fœtal heart was heard at the umbilicus. Most of the liquor amnii had drained away. Patient calculated that she was seven months gone. The hand was passed into the vagina and the os found to be easily dilatable. The presenting hand was pushed up and the right foot grasped and brought down, at the same time making pressure on the breech in the left iliac fossa. A noose of sterilized tape was passed up and secured over the foot now in the vagina, pressure being maintained on the breech. The fœtal head was pushed upwards by the extern towards the fundus uteri. The left leg came down and the child was born alive in about fifteen minutes without difficulty. The uterus contracted well down, but the placenta could not be expressed; after about half an hour an examination was made. The external os and cervical canal were patulous, but firm contraction was found in the lower segment of the uterus proper, admitting two finger-tips with difficulty. This constricting segment was gradually dilated up until three fingers could be passed through in conical form (taking about twenty minutes), and the placenta was then found to be firmly adherent to the posterior uterine wall. As the fingers could not reach the upper limit of the placental attachment, owing to the constriction in the lower part of uterus, the placenta was stripped off from the uterine wall from below upwards and removed. Vaginal douche of 1 : 4000 hyd. perchlor. was given. The pulse remained good all through the operation, and there was very little bleeding. The placenta was pale and fibrous. At the time of writing the patient is doing extremely well.

Case XIII.—*Placenta prævia with arm presenting.*—May 1st. R. P., æt. 21. Primipara. Last period? Thought herself about seven and a half months advanced. Pregnancy normal up to time of labour. Patient was awakened about 5.0 a.m. by some slight pains; on getting out of bed had a somewhat severe flooding, and shortly after this the membranes ruptured. At 6.0 a.m. the nurse who was in attendance found the os too high up to be felt, and as there were scarcely any pains the patient was left. At 10 a.m., the nurse found a hand presenting, and the os about 2/3 dilated, pains very slight. 11.0 a.m. the head could be felt in the right iliac fossa and the breech in the left. Fœtal heart could not be heard. The os was about 2/3 dilated and the right arm was protruding into vagina, the shoulder being tightly gripped by the uterus above. The liquor amnii had practically all escaped and the uterus was closely wrapped round the fœtus, which was apparently dead. On the posterior wall the placenta could be felt immediately inside the internal os and was found to be detached from the uterine wall as far as the finger could reach. The woman's condition on the whole was good, pulse 120. With some difficulty the presenting shoulder was pushed up and the arm returned to the uterine cavity. The abdomen was to the front. Bipolar version was performed and the left foot brought down, after prolonged effort, owing to the slight mobility of the fœtus. When the foot was brought into the os the original arm also tended to present with it, but a noose being fastened round the ankle gentle traction was made while the arm was pushed back, and the head strongly pressed up from the outside. The half breech then entered the os with the back anterior and the head well at the top of the uterus. Strong pains began to come on and the fœtus and placenta were expelled within two hours from the commencement of manipulations. No difficulty with the arms. A few pieces of placenta being adherent, were retained and had to be removed digitally. The placenta was small and thick, with a complete ring of fatty degeneration. It showed the area of ante-partum detachment over about two-thirds of its surface. There was very little loss afterwards, the uterus contracting down well.

R. H. J. SWAN.
W. H. M. TELLING. } Juniors in Charity.

From the Gazette's Special Pathologist.

NOTICES.

H., Ramsgate.—Tubercle bacilli are present in the sputum in large numbers.

S. R. H. M., Bickley.—This breast shows one moderately large smooth-walled cyst, and numerous small cysts scattered through its substance. The structure of the breast is fibroid with atrophy of the glandular tissue, and the cysts are due to dilatation of the smaller ducts. There are no indications of malignant growth in the specimen.

W. W. H., Brighton.—This growth is a carcinoma arising in a pigmented mole of the skin. The surface of the growth is partly denuded of skin by ulceration in the centre, and secondary inflammation.

H. Y. Z., Hastings.—No tubercle bacilli were found in the sputum.

PATHOLOGIST.

Guy's Hospital Dental Society.

A MEETING of the above Society was held on Tuesday, March 13th, at 4.30 p.m. The President, Mr. Baker, occupied the chair. The last minutes having been read and confirmed, Mr. Milligan was called on for his paper on "Some Aspects of Anæsthesia," it being decided to discuss the "Casual Communications" last, as Mr. Milligan was unfortunately compelled to leave early.

SOME ASPECTS OF ANÆSTHESIA.

MR. PRESIDENT AND GENTLEMEN,—From the earliest times man has exhibited an instinct, deeply rooted in his nature, to avoid pain. From the classical writings we find that anodynes were in use hundreds of years before the Christian era, and that they were often most satisfactory in their action.

In the Odyssey, the date of which is given as 1184–685 B.C., Helen is depicted as administering a drug to the guest of Menelaus, and the incident is described in these words:—"Immediately she dropped into the wine of which they drank, a drug, an antidote to grief and rage, inducing oblivion of all ills—he who drinks of this mingled cup sheds not a tear the livelong day. Were death to seize his venerated sire or her who gave him birth, or were the bloody sword buried in the bosom of his brother or greatly beloved sister, no tear would even then bedew his cheek."

It is very probable that the agent here used was opium.

At a later date we find mandrake, which is allied to belladonna, being used by Hippocrates, the Father of Medicine, for the alleviation of pain.

In the Middle Ages narcotics were not unknown, and it is interesting to read in an old tragedy entitled "Women! Beware women!" published in London in 1657, these lines—

"I'll imitate the pities of old surgeons
To this lost limb, who, ere they show their art,
Cast one asleep, then cut the diseased part."

With this brief glance at the classical stage of the evolution of anæsthetics, we will hasten on to what I will call the chemical stage.

The foundations of the modern science of chemistry were laid by Cavendish, Lavoisier, Scheele and Priestley, the last-named of whom made many discoveries which have proved of inestimable benefit to mankind. Priestley was the first to isolate such gases as nitrogen and nitric oxide; and in the year 1772 he gave to the world nitrous oxide, which has been used so extensively for producing "The drunken dark, the little death in life." It is probable the art of surgery would still be in its infancy had not the immortal Priestley, and other eminent chemists, such as Soubeiran and Liebig lived. For how could the abdominal cavity have been opened and explored without such agents as ether and chloroform? That a man cannot live to himself alone we see well set forth in this example, and while we pride ourselves on the fact that the medical profession far exceeds all others in its beneficent effects, yet we should not forget how dependent we are on men who, in the seclusion of their laboratories, have unfolded to us the secrets of the chemical and physical sciences. Priestley's intuitive sense told him that there was a future for nitrous oxide, as we may gather from his work entitled, "Experiments and Observations on different kinds of air," where he says:—"I cannot help flattering myself that in time very great medicinal use will be made by the application of these different kinds of air to the animal system. Let ingenious physicians attend to this subject and lay hold of the new handle which is presented to them." The ingenious man soon appeared in the person of Humphrey Davy. He first practised on mice and then tried the effects of the gas on himself, the action of which he described as "producing a peculiar intoxicating effect." One day, while suffering from neuralgic pain, caused by an erupting wisdom tooth, he found to his relief that the pain had totally disappeared after taking a few inhalations of "laughing gas," as it was then popularly called, because of the excitement produced when taken in combination with air.

But Davy soon abandoned the use of the gas, and we hear nothing of it till half a century later when, in the year 1844, we find a Dr. Coulton giving popular demonstrations on the effects of nitrous oxide. At one of these entertainments held in Hartford, Connecticut, there was a dentist present named Horace Wells. One of the audience inhaled an impure sample of the gas, and became so excited that in his struggles his leg sustained a severe injury without causing him the least pain. The idea at once struck Wells that if the gas could make a person oblivious of pain, he might use it during dental operations. Accordingly he asked Dr. Coulton the next day, to administer nitrous oxide to him, while his friend, Mr. Riggs—another dentist—extracted one of his molars. Dr. Coulton acceded to his request, and when he awoke from his sleep to find that the tooth was really removed, he exclaimed "A new era in tooth pulling!"

But poor Wells was doomed to disappointment. He went to Boston and got permission to make a public trial of the gas at one of the hospitals in that city. A sceptical crowd gathered to see the exhibition. Either Wells was so nervous that he did not give enough gas or else the operation was too slow. At any rate, the patient uttered a scream before the tooth was extracted and the crowd hissed and treated Wells as an imposter. He was of a nervous disposition and never again appeared before the world, but fell into obscurity.

Dr. Coulton seems to have continued using the gas, but we hear very little of it until he came over to London and introduced it at the Dental Hospital, Leicester Square. From that date it has had an unchequered career, not only in this country but throughout the civilized world. Having hastily glanced at the history of nitrous oxide, let us now turn to some of the details associated with its administration and physiological effects.

In choosing an anæsthetic the first thing we must consider is its safety, and there is no difficulty in coming

to a decision on that point. Nitrous oxide has been administered to some millions of people during the last twenty-five years, and yet the fatalities occurring under its use may be counted on the fingers of one hand. What a grand record as compared with that of chloroform! And this is particularly worthy of consideration when we remember the class of case in which chloroform is sometimes fatal. Look through our Medical Journal or the *Lancet* and what do you see? A fair percentage of the deaths under chloroform take place during dental operations; cases where nitrous oxide is deserving of a place, or if not nitrous oxide alone, at least nitrous oxide combined with oxygen or ether. Some one may say, "It is unfair to condemn men who have been unfortunate enough to meet with such misfortunes, without knowing the particulars of the case." Now, the reason that many general practitioners prefer to give chloroform lies in the fact that they have not been taught the administration of nitrous oxide, and the Examining Board is most to be blamed for not making the curriculum more thorough in this special branch of medicine. The practitioner acts up to his knowledge and is compelled to give chloroform because often that is practically the only anæsthetic he has been taught to administer. Fortunately the schools are now taking the matter up and giving students special opportunities for learning how to administer all the anæsthetics in common use, and no doubt the medical profession will, as a result, fall in love with the, at present, greatly despised nitrous oxide, and will not hesitate to give it at the request of the dental surgeon.

The special advantages of nitrous oxide over chloroform and ether are:—

1. That it is safe.
2. That such a preparation of the patient as starving is not essential, although it may be advisable.
3. That it may be administered with equal safety either in a sitting or a reclining posture.
4. That it is pleasant to take and quick in its operation.
5. That recovery is rapid and is not often followed by disagreeable effects.

I need not remind you what a boon it is to the dental surgeon that he possesses an anæsthetic which can be safely administered to a patient while in a sitting position. It would be a most dangerous procedure to administer chloroform to a person who was in any other than the reclining decubitus, but nitrous oxide can be safely given as he sits in the dental chair. The reason for this is that while chloroform depressed the action of the heart, nitrous oxide has no such effect. In my opinion nitrous oxide is more effective if the patient assumes a natural and comfortable sitting posture; the explanation of which is doubtless to be found in the fact that the anæsthetist has greater control over the patient and can the more effectively manipulate his apparatus. Generally speaking, patients like gas better than chloroform or ether. Ether is most objectionable to inhale, and chloroform is often followed by vomiting for hours after its anæsthetic effect has passed away.

A few objections to gas have been raised from time to time, but the only one of any consequence is that the stage of anæsthesia is too short for performing any but the simplest operations. It will be my endeavour to show that the period of unconsciousness can be prolonged considerably by using gas in combination with oxygen or air.

Suppose a lady to come to one of us for the purpose of having teeth extracted and desires an anæsthetic, how are we to decide what anæsthetic to give?

Chloroform is not to be considered for a moment, for there is a general concensus of opinion that it has no place as an anæsthetic in dental surgery. The danger attendant upon its use does not warrant its administration for so simple an operation. Ether, however, is not to be disposed of in the same way, for there are dental cases in which its use is legitimate as well as necessary, but it behoves us to avoid it whenever we can effectively give nitrous oxide alone or in combination with oxygen. If three fairly easy teeth are to be removed one may try nitrous oxide alone, but the period of unconsciousness is not generally long enough for the extraction of more than this number. If the third tooth is not successfully removed a second administration of the gas may be made, when it will be noticed that so much gas is not taken as at the first administration. This is explained by the condition of the blood, which is still partly saturated by what remains of the first dose. If the patient is strong and healthy and shows no unpleasant symptoms there is no reason why three or four consecutive doses of the gas should not be given. But it appears to me that repetition is a lame method when we have at our disposal the apparatus for giving nitrous oxide and oxygen together, a combination which permits of a much longer period of unconsciousness being obtained.

There are some few individuals who may not be subjected to nitrous oxide or any such other agent. I refer to those cases of advanced phthisis and profound anæmia where the oxygenation of the blood is very deficient and in which any additional impediment to the formation of oxyhæmoglobin is likely to result in asphyxia. Where oxygen is used at the same time as the nitrous oxide the risk of such a disaster is much reduced.

We are sometimes asked if it is safe for a person with a weak heart to take nitrous oxide. It is my experience that most female patients above the age of thirty-five are intensely gratified if they have been told that the heart is a little weak. They like to consider themselves pathological specimens capable of striking awe into the soul of the young practitioner. In ninety-nine per cent of these cases there is no clinical sign of a cardiac lesion; and supposing one does find signs of mitral or even aortic disease, there is no reason why the anæsthetic should not be given if there are signs that compensation is present. Advanced pregnancy is not a contra-indication for nitrous oxide, although it may be the wiser plan in such a case to avoid as much as possible the asphyxiating effects by adding a little oxygen to the inhalation.

(To be continued).

Obituary.

Stanley Whicher,
M.B. Lond., M.R.C.S., L.R.C.P.

It is with great regret that we note the death of Stanley Whicher, M.B. Lond., M.R.C.S., L.R.C.P., Civil Surgeon attached to the R.A.M.C., of enteric fever, in Bloemfontein. Mr. Whicher entered Guy's as a Preliminary Scientific student, in the winter of 1890, and passed the second examination of the Conjoint Board in 1893. The following year he passed the 1st M.B. Lond., and three years later obtained the double qualification of the Conjoint Board, and also the M.B. London. Besides the usual appointments, Mr. Whicher was a dresser in the Throat department, and was also an Obstetric Resident. In December of last year, Mr. Whicher was appointed a C.M.O. attached to the R.A.M.C., and it was in this capacity that he contracted his fatal illness. His loss will be keenly felt not only among Guy's men, with whom his genial personality made him a ready favourite, but in the Artists R. V., of which corps he was an enthusiastic member.

Personal Reminiscences of Malarial Fever.

For many months past the writer had been in very indifferent health. The cause of it puzzled him. The symptoms were a general tiredness after moderate exercise, excessive perspiration, cold shivers down the back, aching of the limbs, and shortness of breath. At last, after putting it down to Malta fever and influenza, it occurred to him to examine the blood. The first examination was made on April 4th. Four coverslips were used. The slips were inoculated with blood from the lobe of the ear. A piece of cigarette paper took up the blood from the ear (which was punctured by a sterilised surgical needle). The blood was then smeared over the four coverslips, and the coverslips then placed in Absolute Alcohol for ten minutes. They were then dried, and stained for sixty seconds in Eosin, dried, and stained in Aqueous Methylene Blue for ten minutes, dried, and mounted in Canada Balsam. The greater part of the red blood corpuscles contained typical malarial corpuscles, hyaline on focussing, and of a black colour.

Another examination was made on April 7th, and another on April 10th. The improvement was considerable. Fewer of the corpuscles contained malaria corpuscles. The writer had been taking ten grains of quinine daily.

Further examination was made on April 10th, as the temperature in the afternoon rose to 102°. The last examination was made on April 18th, no quinine having been taken since April 10th, and the temperature of the body in the afternoon being 102°. In some portions of the slides nearly every blood corpuscle contained from four to ten malarial parasites. Every form of the parasite has been observed—

1. The spherical.
2. The crescentic.
3. The flagellated.
4. The rosette shape.

The treatment by quinine has, therefore, been re-commenced. The writer considers that he must have contracted the disease at Annesley Bay, on the west coast of the Red Sea, in January, 1899.

It may interest your readers to know that "amœbae" are injuriously affected by so little as a $\frac{1}{50000}$th solution of quinine hydrochlorate. A control experiment was made with blood from the lobe of the ear of my wife, and every corpuscle was healthy.

W. J. M.

Multiplicity of Lesions.

What a large number of severe organic lesions may be compatible with life, is shown in the case of Robert T., an ex-private in the 6th Dragoons, who died in the Grove Hall Asylum recently, æt. 72 years. He was found to have:—

1. Complete atheroma of the vertebral basilar, and both middle cerebral arteries, the latter being nearly obliterated.
2. Bony calcification of both coronary arteries in their entire length, so as to resemble clay pipe stems.
3. Heart: all cavities dilated, fatty infiltration and extremely friable muscle walls.
4. Atrophic cirrhosis of liver, which weighed only 43 ounces.
5. Large red kidneys, with incipient softening and atrophy of cortex.
6. Large spleen with fibro-cartilaginous capsule, 14 ounces.
7. Broncho-pneumonia and œdema of both lungs. In the right lung, the base of lower lobe was much infiltrated, portions slowly sinking in water. Right lung weighed 48 ounces.
8. Gangrene of right foot following ulceration and lymphangitis.
9. Purpuroid extravasations in various parts of the limbs and trunk, some extensive in size.

He had several attacks of jaundice in 1897, and his face was somewhat deeply icteric in hue. It is interesting to note that he never had ascites, nor any anginal attacks at any time, though his heart was intermittent in rhythm. The end was due to the gangrene and pulmonary changes.

Patient was getting about until April 22nd, when the lymphangitis set in, determining the fatal issue. Mentally, he believed himself to be 1000 years old, and extremely wealthy, and the owner of this institution.

E. I.

Testimonial to Dr. Starling.

ON March 24th of this year Dr. Starling delivered his last lecture at Guy's. It is with feelings of the deepest regret that we bid him farewell.

As a lecturer on physiology, Dr. Starling is inimitable. His lectures, always full of life and sparkle, light up the dim mazes of a bewildering subject like a friendly lantern. The complex becomes simple, the simple obvious. This is brought about, not by wearisome reiteration or excessive detail—the first year intellect would resent being fed with a spoon—but rather by perfection of system and originality of treatment.

Of Dr. Starling's personal charm and of his achievements in the world of physiological research, it is needless to speak; they are known to us all. We shall always be proud to think that some of the standard experiments of modern physiology were first made in the laboratories of Guy's. The new theory of lymph-formation and detailed knowledge of the mechanism of peristalsis are perhaps his most important results.

Since 1882, Dr. Starling's sphere of action has centred round the hospital. It has ever been his ambition to make the School of Science at Guy's as efficient and as famous as her Clinical School. No one has done more than he towards this end. Among many other points we may notice the institution of an annual hospital prize for physiology and the starting of a practical class for first year's men, while Starling's text-book came as a boon and a blessing to all conjoint men. The idler may now cross the park and show his admiring cousins the "finest physiological labs. in London" without any qualms of conscience as to his strict impartiality.

In brief, we feel that there is no danger either of Guy's forgetting Dr. Starling or of his forgetting us. Yet it seems fitting that some slight token of our esteem should be presented to Dr. Starling on his leaving the hospital.

Will all Guy's men who have known and worked under him please respond?

Several students will be collecting names and subscriptions during the next few days, and we shall be glad to receive and acknowledge subscriptions through the medium of the GAZETTE.

P. R. B.

Sport.

Cricket.

GUY'S 2ND XI. v. OLD CHARLTON 2ND XI.
(WON BY 1 WICKET AND 49 RUNS).

Played at Charlton on Saturday, May 5th. Of the new men playing, Morres and Collins showed good batting form. The latter's fielding is somewhat uncertain.

Gardiner performed excellently behind the wicket. Wetherell put together 39 runs in good style. Scores:—

GUY'S.

H. Barber, c Houghton, b Manning	1
F. Morres, c & b Houghton	26
E. A. Collins, b Houghton	18
M. C. Wetherell, c Lambert, b Manning	39
A. H. Turner, b Houghton	8
H. T. Palmer, c Penstone, b Leaney	12
J. T. Hicks, c Bell, b Manning	26
E. W. Strange, b Manning	1
H. W. Bush, b Houghton	11
G. Carlisle, not out	8
J. Gardiner, not out	0
Extras	13
Total	163

OLD CHARLTON.

Leaney, b Morres	15
Clough, run out	3
Penstone, b Wetherell	13
Tate, b Morres	9
Dawes, b Wetherell	4
Lambert, b Carlisle	26
Bell, c Palmer, b Carlisle	25
Houghton, c Collins, b Carlisle	1
Lomas, c Strange, b Hicks	2
Kemp, c Gardiner, b Hicks	4
Manning, not out	1
Extras	11
Total	114

Marriages.

DUFFETT—WOOD.—On April 28th, at St. John's Church, Upper St. Leonards, Henry Allcroft Duffett, F.R.C.S., of Witby Holt, Sidcup, Kent, to Elizabeth Gertrude, daughter of Charles Wood, of Charles Road, St. Leonards-on-Sea, and Lincoln's Inn, Barrister-at-Law.

NORMAN—CHEESE.—On April 25th, at St. Mary Abbots, Kensington, Albert Norman, L.R.C.P., F.R.C.S., F.R.M.S., youngest son of the late James Norman, of East Southernhay, Exeter, to Julia Elizabeth, youngest daughter of James Cheese, of Cornwall Gardens, South Kensington.

Deaths.

ARCHDALL.—On April 20th, in London, Henry Stewart Archdall, M.R.C.S., L.R.C.P., late Surgeon, Royal Navy, aged 32 years.

DAVIES-COLLEY.—On May 8th, at Borough, Pulborough, Sussex, in his 58th year, John Neville Colley Davies-Colley, M.A., M.C. (Cantab.), F.R.C.S., late Surgeon of Guy's Hospital.

WHICHER.—On April 27th, at the Mooi River, Natal, South Africa, of enteric fever, Stanley Whicher, M.B. Lond., Civil Surgeon, attached to the Natal Field Force.

ED.—S. H.

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Calendar of Coming Events.

May, 1900.

Sat. 26—Messrs. Jacobson and Fripp's take-in; Drs., C. B. Penny and M. J. Rees; Cl., G. Lewin.
Last day for applying to Registrar for Form of Entry for Intermediate M.B. Lond. Exam.
1st and 2nd year's Dental Students Laboratory Exam. for Prizes, at 9 a.m.
G.H.C.C., I., Beckenham, away.
II., Dulwich, home.
G.H.L.T.C., I., Harold, home.
Hos.-Scho. C.C., Sydenham Albion, away.

Mon. 28.—1.15 p.m. Clinical lecture by Dr. Perry.
G.H.S.C., Grafton, Southwark Baths.

Wed. 30.—1.30 p.m. Clinical lecture by Dr. Hale White.

Thur. 31.—Messrs. Howse and Symonds' take-in; Drs., C. E Gaitskell and D. R. T. Griffiths; Cl., E. W. Goble.
G.H.C.U., Address by Rev. W. R. Mowll.

June, 1900.

Fri. 1—1.15 p.m. Clinical lecture by Mr. Lane.
July Appointment List opened.
Last day for names to be sent in for 1st and 2nd M.B. Camb. Exam.
Special Exam. for Dental Operative Prize, Conservation Room, 9 a.m.
G.H.S.C., Tadpole, Southwark Baths.

Sat. 2.—Last day for applying to Registrar for form of Entry for a Prelim. Scientific Lond. Exam.
G.H.C.C., I., Reigate Priory, away.
II., St. Thomas's, home.
G.H.L.T.C., I., Kent L.T.C., home.
II., St. Bart.'s, away.
Hos.-Scho. C.C., St. Bart.'s, home.

Mon. 4.—Whit Monday. Medical School Office closed.
G.H.C.C., Eltham, away.
Hos.-Scho., C.C., Gt. Northern Hosp., home.

Tues. 5—Exam. for Treasurer's Gold Medal begins.
G.H.S.C., Old Coburg, Southwark Baths.
12 o'clock, Mr. Rowell's Demonstration on Anæsthetics.

Wed. 6.—1.30 p.m. Clinical lecture by Dr. Hale White.
G.H.L.T.C., I., Weighton, home.
II., Addiscombe, away.

Thur. 7—Messrs. Lucas and Lane's take-in; Drs., H. S. French and H. K. Lacey; Cl., H. McD. Parrott.
Application to Medical School Office for Schedules for the Second Conjoint Exam. to be made not later than this date.
G.H.C.U., Address by Rev. G. R. Thornton.

Fri. 8.—1.15 p.m. Clinical lecture by Mr. Lane.
July Appointment List closed.

Sat. 9—G.H.C.C., I., Waldegrave Park, home.
II., Croydon, away.
G.H.L.T.C., I., Redhill, away.
II., Gipsy, home.
Hos.-Scho. C.C., Park, away.

Guy's Hospital Gazette,

MAY 26, 1900.

Two Cases of Intestinal Obstruction.

CLINICAL LECTURE BY DR. TAYLOR.

March 3rd, 1900.

GENTLEMEN,—The first case that I have to bring to your notice to-day is that of a man, aged fifty-eight, who was admitted on Wednesday, February the 21st, for gastric pain, vomiting, and constipation. He was perfectly well up to the Saturday preceding. At 10 a.m. on that day, soon after breakfast, at which he took toast and bacon, he was suddenly seized with violent pain in the abdomen which he referred to the umbilicus. It was so intense that the patient writhed, according to his daughter's words. He went to bed and sent to the chemist for a draught for flatulence. He "took oil on Monday with no result"—no doubt castor oil—and also liquorice powder. On Monday afternoon he retched and brought up a small quantity of bilious matter. On Tuesday he took another dose of liquorice powder and soon after this he vomited, the vomit being greenish in colour and having a fæcal odour. You will notice the very early occurrence of fæcal vomit. He continued to vomit similar matter until February 21st, at 3 p.m., and under that date the report says: "The bowels have not yet been opened with any material result. His food since Saturday

17th has consisted simply of milk. He states that he has not wasted or lost weight in any way until the last few days."

On admission, his pulse was 100 and his temperature normal. "He looks pale, but his face is not particularly pinched or wasted, the eyes are not sunken, his body and limbs do not appear wasted, he is not distressed, and does not appear to be in any pain. He says he feels sick, but has not vomited since admission. This morning he brought with him a bottle containing vomited matter which is greenish in colour and has a distinctly fæcal odour; it contained some bile, but no free hydrochloric acid could be detected." To me, the odour was not strongly fæcal, but rather a mixture of the gastric and fæcal smells.

"His lips are somewhat dry, and the tongue is red with some white fur and not very dry. The abdomen is full, but is not distended, and moves without pain on respiration. There is some redness around the umbilicus which patient says is due to a poultice. There are no abdominal veins visible, and no lumps, and no signs of peristalsis can be detected. The abdomen is somewhat tympanitic all over, but distinctly so in the gastric area. No dulness in flanks, no thrill or any sign of fluid, no pain on palpation, no abdominal pulsation. But although no mass can be felt anywhere, there is an undue sense of resistance on palpation, especially from the umbilicus upwards. The liver and spleen could not be felt. Nothing abnormal can be felt on making a rectal examination."

I suppose one might admit at once that the general appearance of this case was that of intestinal obstruction. We know that the characteristic symptoms of a typical case of acute intestinal obstruction are commonly: a rapid onset, frequently with pain, the occurrence of vomiting, the entire absence of the passage of either fæces or flatus per anum, a gradual yet rapid distension of the abdomen; and if such a condition of affairs persists for some days without relief the patient becomes exhausted, loses flesh, has a sunken appearance about the face, the eyes sink in and dark rings appear around them, the tongue becomes dry, the patient is restless and sleeps little, and perhaps gets drowsy, the pulse gets smaller and weaker and more rapid, vomiting becomes more persistent and stercoraceous or fæcal, and death takes place.

You will remember that the onset was accompanied with pain, though it is interesting to note that when the patient came in some time afterwards pain was practically absent. He had vomiting which appears very early to have assumed the characters of fæcal vomiting. On the Tuesday morning he vomited this greenish fæcal matter, but the day before he had vomited simply bilious fluid. So that on the third day he vomited gastric material, and on the fourth day he was vomiting fæcal or stercoraceous fluid. Then he had constipation. It is stated that there was "no material result" from enemata that were given; only small quantities of bilious fæcal matter were evacuated; there was no considerable or complete mass of fæces discharged.

For several hours after admission the patient appeared perfectly comfortable, there was no repetition of the vomiting which had occurred before admission. But on the following morning about eight o'clock, I think it was, he began to vomit again. He vomited a considerable quantity; I saw two vessels, one I should think containing over two pints of much more fæcal material than was present before, that is, more brown, thick, foul stuff with a pronounced fæcal odour. As a result of that I do not know that the difference in his condition was very great, but still he was no better. He passed no more definite motion, he did not pass any flatus, and his condition did not improve.

Upon the fifth day the resemblance to intestinal obstruction was very striking. The important feature, no doubt, was the fact of fæcal vomiting. Now fæcal vomiting is perhaps not absolutely distinctive of intestinal obstruction, though undoubtedly it occurs most frequently in association with it. If you get complete obstruction, whether it occurs acutely or is of slow development, yet unless relief is afforded we know that eventually the contents of the bowel are passed upwards and in some form or other evacuated by vomiting.

There is a rare condition known as *gastro-colic fistula;* that is, a communication between the stomach and the transverse colon may be a cause of fæcal vomiting. Now this gastro-colic fistula, I think, we can at once exclude. On the one hand, it is exceedingly rare—of course that mere fact does not altogether exclude it; on the other hand, it is commonly the result of a communication by malignant disease, or possibly by a gastric ulcer between the stomach and colon. In either of these cases, of course, the condition is a chronic one. Gastric cancer, or cancer of the colon, must exist for a certain time, and the high probability is that before a perforation or communication takes place between these two hollow viscera,

the patient will experience some such symptoms as to force him to consult a medical man or come to the hospital, and the existence of a lesion would be known. There is nothing of the kind in the history before us. The same remarks would apply to probably very much more rare cases of the communication of a gastric ulcer with the colon. Then in the case of gastro-colic fistula, there is not necessarily any obstruction. Of course fæcal matter may be vomited, and therefore there would be less fæces to pass in the other direction, but there is not necessarily obstruction to the passage of fæces at all, or of flatus.

Then you get fæcal vomiting is cases of *peritonitis* where there is no definite mechanical obstruction; that is to say, if the intestines are paralysed by the condition of peritonitis, and are not able to act by peristalsis in a normal direction, there may be some expulsion of the contents of the intestines in an upward direction, and fæcal vomiting will take place.

Now, further, with regard to peritonitis. Of course acute peritonitis, we know perfectly well, may come on with symptoms very similar to those we have in this case. Numbers of cases of appendicitis occur as follows:—The patient is taken with severe pain, he has vomiting, he has paralysis leading to constipation and more or less distension of the abdomen, and is acutely and dangerously ill within a few days; and there is often much difficulty in distinguishing between these cases and cases of acute obstruction. In the special case we are considering I think that the points as against peritonitis were, first the absence of fever: although we know that in suppurative peritonitis fever is not always present. In this case there was also absence of great distension and tenderness, so that some of the most characteristic features of peritonitis were not present. Therefore we were thrown back almost at once upon a diagnosis of acute intestinal obstruction. The patient had a sudden attack of pain such as might result from a twist or a band in the intestine, or the intestine might have been forced through a loop or hole so as to be constricted. These are conditions that occur, for instance, in external hernia.

Well, then, were there no objections to this condition being one of intestinal obstruction? The only objections I think one could raise were these: the amount of collapse which the patient showed on the fifth day of his illness was not very great, and did not seem to correspond to the fact that he was taken so acutely ill—the pain left, and he soon after revived. And, again, there was very little distension and nothing like the great distension and tenderness, and great fulness that commonly accompany most cases of acute intestinal obstruction.

Now the answer to that last objection is simply this: if you get obstruction high up in the intestine, that is, in the duodenum or in the upper part of the jejunum, the distension of the abdomen is much less than it is in the larger number of cases. For in most cases the lower parts of the bowel are involved in strangulation; and hence a large part of the bowel remains above the point of obstruction, in which gas and fluids accumulate because they are unable to proceed any further downwards. For instance, in hernia, the position of the hernial rings makes it likely that the portion of the bowel strangulated will be in the lower part. In cases of strangulation by Meckel's diverticulum the lower part of the bowel is involved because it is the lower part from which the diverticulum is given off. And all cases of obstruction of the large intestine illustrate the same point. Thus, since in a large proportion of cases of intestinal obstruction the lower part of the bowel is involved, great distension of the abdomen is a common factor of intestinal obstruction. But if, on the other hand, by any accident whatever the upper part of the intestine alone is involved, then of course there is a smaller extent of bowel above it to be distended, and therefore less opportunity for a great distension of the abdomen. When we had made up our minds, on account of the recurrence of the fæcal vomiting, that intestinal obstruction was almost a certainty, then this absence of abdominal distension made us suppose that the obstruction was in the upper part of the bowel, or at any rate, not very low down.

Having made the diagnosis of intestinal obstruction we quickly came to the conclusion that an operation was desirable. We know that with regard to curing an acute intestinal obstruction we have long given up any idea that purgatives are of service, and we must also abandon the view that the administration of opium and belladonna and other sedatives is likely to do much good. If you realise that acute obstruction is present, whether you understand the exact nature of the obstruction or no, the only safe method of dealing with the case is to perform an exploratory operation, and this is what we did in the present case.

Mr. Symonds made an incision in the middle line below the umbilicus, and then found that one part of the small intestine was considerably

distended, while a portion below it was completely collapsed. Having found the point at which the one changed into the other, it was not easy to say what was the cause of the constriction at that particular point. There were certain tissue changes in the substance of the wall of the intestine, and there was a curious appearance along the mesentery adjacent as if it might be a trace of a vessel or some cicatricial tissue, running from the seat of constriction obliquely on to the mesentery. The only thing one could suggest was that there had been a bend or kink of the intestine at that point, or possibly it had been nipped by a band or sharp edge; but no band was found at the time, and no aperture or hole in the mesentery or omentum. But one knows that when patients have been operated upon, or even after a post-mortem, in such a case it is not always easy to realise exactly the condition of affairs which has brought on an obstruction; that is, by the time that you have displaced the intestine, and the anatomical relations of the parts have been altered, and perhaps secondary inflammatory changes have occurred, you cannot then demonstrate that an obstruction is present, though all the preceding history points conclusively to the fact that such an obstruction was in existence. That was our position here. Well, Mr. Symonds having got so far, and finding there was apparently a good passage along this part of the bowel, and that it was not nipped, made an incision in the left side some distance from the middle line, and fixed a portion of the distended intestine at this spot with the intention of making a fæcal fistula above the constriction, in case it should prove after a few hours that the bowels were not adequately opened by passage through the apparent seat of the former constriction.

I need not go into every surgical detail of the rest of the case. Suffice it to say that the patient passed one or two yellow fluid motions shortly afterwards, and that his condition improved very much within some twelve hours after the opening was made. Ultimately also a fæcal fistula was effected at the point provided so as to give complete relief to the upper part of the bowel, but in spite of this the patient gradually became more and more collapsed, and died on the third day after the operation.

And now as to the post-mortem, we have the following account. There was a slight amount of peritonitis over some collapsed coils of intestine. There was a band found in the region of the iliac fossa, and it was attached to the iliac fossa at one end, and at the other end to the small intestine; it did not form any narrow opening through which a strangulation would necessarily take place, and it was quite impossible to say whether this band had formed a means of strangulating that portion of the intestine or not, or what share it had in producing the obstruction. The constriction that was found presented itself after death in precisely the same form as it did during life; it was situated about eight feet above the cæcum, so that it was somewhere about the upper part of the ilium and the lower part of the jejunum. That was of course relatively high in the bowel, but perhaps not so high as I was prepared to believe.

Let us now turn to the second case which, so far, has been more successful. The patient is fifty-four years of age, and he was admitted into Philip ward on January 11th, and transferred to Clinical ward on February 19th. "He was first ill in August last and suffered from diarrhœa for ten days; he was slightly sick, but got quite well again. At the end of September he became ill, with vomiting, which has continued up to the present time." The vomiting is described in this way: "Sometimes he has vomited for three or four days, and generally about two or three hours after a meal. He describes the stomach as feeling distended and giving him great pain, which he says is of a griping character. The vomit, which was of a brownish colour and very profuse—sometimes amounting to two quarts—was thickly fluid, and the patient says it sometimes has froth on the top. On Tuesday last"—a few days before his admission—"it was of a greenish colour and much less; the patient says this is because he does not eat much. During the last two weeks he has been living on bread and milk and beef-tea. He has lost flesh considerably. The abdomen is tense and slightly distended. The distension is equally distributed and symmetrical. There is no lateral bulging. The abdomen moves well on respiration, especially in the epigastric region; both sides move equally. After careful watching no peristaltic movement can be detected. Little can be made out by palpation owing to the great rigidity of the abdominal muscles. The liver cannot be felt. No part of the abdomen is dull, but there is a hyper-resonant note in the middle line as far down as the umbilicus."

The first suggestion that was naturally presented to us in reference to this case was that the patient had a dilated stomach. When a patient for three or four months suffers from sickness, and some pain or distension or

distress at the stomach, and is unable to take food very comfortably, and each time he is sick, vomits up large quantities of fluid matter which is brown or greenish-brown in colour, with froth on the surface, the possibility of dilatation of the stomach is suggested. Supposing the stomach from any cause is dilated, the food is liable to be retained, as the dilated stomach has not got the same power of contraction on its contents as a normal stomach. The food is not passed through the pylorus, either because it is obstructed originally or because the parietes of the stomach have not the same muscular power as they normally have. After a time so much food accumulates that it is vomited, and while accumulating it ferments and forms this frothy condition that I have spoken of. Dilatation of the stomach is often accompanied by another symptom for which we were constantly looking, namely, a frequent recurrence of visible peristaltic movement over the dilated viscus. The patient came in on January 11th, and on the 12th they were looked for, but not recognised, on the 19th there was no peristalsis, nor was there any on the 25th. On February 5th peristalsis was at length seen; it was not, however, in a position corresponding to the stomach; but in the left flank and inguinal region corresponding closely with the position of the sigmoid flexure. At a point somewhat above the left iliac spine the abdomen would become hard and prominent, then this was converted into a large elongated prominence, stretching downwards and inwards along Poupart's ligament, and after the whole thing had remained hard and tense for some thirty seconds it would subside, first at the upper end, and then throughout its whole length.

Now could this dilated viscus be the stomach? And was it due to an obstruction at the pylorus? There is no doubt that you may get very considerable displacement of the stomach in cases where it is dilated, for if the stomach dilates it cannot occupy exactly the same position with the same limits that it does when it is not dilated.

Normally the pylorus lies very close to the middle line, and the lower border of the stomach projects not very far below the costal margin; the left lobe of the liver lies across the epigastrium and the stomach comes a little below it, but varies, of course, with conditions of physiological distension. When you have a pyloric cancer, which, as we know, tends to obstruct the pylorus and cause dilatation of the stomach — and supposing that dilatation has already taken place—the enlargement of the stomach will manifest itself usually by an encroachment of the organ upon the abdomen towards the umbilicus. In higher degrees of gastric dilatation you very often get the epigastric region flat, corresponding to a space *above* the displaced stomach, then at the lesser curvature there is a rise from the flat plain over (shall I say) a kopje, caused by the distended stomach and hardened stomach wall, and then a descent down the other side of the kopje to the greater curvature at the level of the umbilicus, or even lower down.

As an example of the great amount of displacement which the stomach may suffer in consequence of this disease, I have seen certainly a pylorus enlarged by growth and situated in the right iliac fossa, the dilated stomach lying vertically above it. In the hypertrophied walls of such an enlarged and dilated stomach arises the peristalsis of which I have spoken, a hard globular mass rising up, and moving like a wave by successive elevations and subsidencies from the left costal margin to the middle line or umbilicus, the whole process recurring from time to time, and the apparent movement always being in the same direction.

Could the position of the peristalsis in our case be explained by an extreme displacement of the stomach? The difficulty was that there was no obvious connection between this peristaltic area and the space where we know the stomach must be in, namely, the upper part of the left side of the abdomen. The peristaltic movements did not start from under the ribs. The stomach must be connected with the œsophagus, the stomach cannot detach itself or get away entirely from its connections, and on the whole, in spite of the "gastric" character of the patient's symptoms it was difficult to believe that this misbehaving part of the alimentary canal was indeed the stomach itself.

In pursuance of what I have just said in reference to the alterations of anatomy as a result of disease, perhaps I may remind you of one or two points that occur in connection with *intestinal* obstruction. If you get an obstruction involving the colon, descending or sigmoid, then you will find that the tranverse colon becoming enormously distended can only find room for itself by bending on itself. The middle part of it travels down towards the pubes, and the whole forms a loop consisting of two *vertical* coils, one on either side of the umbilicus. Thus the single transverse colon becomes two vertical colons, and unless you are aware of this tendency you may be misled by the appearance of the

abdomen as to the situation of any obstructing lesion.

Another fact is this. The small intestine may get enormously distended, so much so that you can very easily mistake it for the large intestine. Therefore you must be careful that the actual size of the distended intestine does not guide you too much, or mislead you in connection with this subject.

If you see three coils side by side in an oblique position, more vertical than transverse, they are almost certainly small intestine, however big they are. In the present case, it was only one coil that I saw on the first occasion when we noticed the peristalsis, but subsequently I saw indications of two other coils parallel with it and therefore at an angle with the vertical line, but they were never so prominent as that first observed.

Further, with regard to this question of peristalsis, what is the value of it? I have assumed that it is of actual pathological or diagnostic value, and shown that our diagnosis in this case was waiting very much upon this condition of affairs. Why should there be peristalsis like that? Is there not natural peristalsis? Of course there is. The pathological value of peristalsis lies not in peristalsis as such, but in the fact that we see it. We ought not to speak of this peristalsis as if in itself it were wonderful. What is unusual is that the peristalsis is *visible*. Peristalsis we all have even those who suffer very much from constipation. But it is visible peristalsis that is of importance clinically.

Why then is there visible peristalsis? Well, for two reasons surely. If we habitually had nothing between the surface and our intestines but a thin layer of peritoneum, I suppose we should always have visible peristalsis; that is to say, if there were only a thin layer of structure between us and the bowel, we could see the peristaltic movement going on. The reason why the movement is not seen is because the parietes of our abdomen are both thick enough on the one hand, and perhaps elastic and tense enough on the other, to prevent the peristalsis being visible. If you have very thin parietes, you can often see the peristalsis under conditions in which there is no reason to believe that there is any disease. On the other hand, if you have excessively violent action, then it becomes visible in spite of the fact that the parietes are thick and elastic. Therefore, it is not only a question of increased peristalsis that has to be considered in these cases, but also the character of the parietal structure.

It is often stated that visible peristalsis practically means chronic obstruction, on the grounds that it would be only visible when the intestine was hypertrophied, and hypertrophy could only occur after a certain lapse of time, and that lapse of time implies chronic instead of acute intestinal obstruction. I think it is admitted that that is not absolutely true, that in certain conditions you may get very violent peristalsis in acute obstruction, and if the parietes are sufficiently thin the peristalsis may be obvious. Therefore, you have got to consider the condition of the bowels together with the condition of the parietes.

We will now go back to our case. This peristalsis was watched, and the next position was this: we had reason to believe that there might be obstruction giving rise to a dilated stomach, but the situation of the obstruction in the pylorus was not confirmed by the peristalsis. We then directed that his stomach should be washed out, and that the amount of relief afforded by washing should be noted, so that we might possibly draw such inferences therefrom as would help us in the case. Accordingly the patient's stomach was washed out, and large quantities of vomit and fluid, as much as two and a half pints altogether, were obtained by means of the stomach-pump, thus apparently confirming the view that the stomach was dilated.

There are many cases of dilated stomach in which washing out does a great deal of good. If the obstruction at the pylorus is very great, and especially if the dilatation is not really due to obstruction of the stomach, but due to primary weakness of the stomach walls, then washing out of the stomach persistently carried on for some weeks will sometimes bring about a complete contraction of the stomach to its normal condition, and practically lead to the recovery of the patient. Some years ago I had a patient who appeared to be in this condition; he had all the signs of a dilated stomach. His stomach was washed out for three or four weeks through a large indiarubber tube, and the patient continued the treatment himself for some time longer. I saw nothing of him again until about five years afterwards, when he returned to the hospital simply because he had some dyspeptic symptoms which he wanted to have treated before they became too severe. There was no trace of a dilated stomach, and the dyspepsia was put right and he went out again. There was an instance of a dilated stomach where treatment by "lavage" was completely

successful, and left the patient practically well for five years, and probably much more.

But though this measure was repeated in our case a few times no improvement was gained. The patient lost flesh, he did not take food regularly, and after the lapse of two weeks or more from the time that we had first seen the peristalsis we decided that the case was one on which we must operate in order to find out exactly what was the condition of affairs, and to give him such relief as this further knowledge might enable us to.

Accordingly, on February 24th, Mr. Symonds opened the abdomen. He first examined the stomach, and saw that the pylorus was perfectly healthy, and there was no very great distension of the stomach. On examining the intestine, that is, the duodenum, he found that it was distinctly distended, and pulling up more intestine from below he came upon intestine which was collapsed. And so he found, as in the other case, collapsed intestine and distended intestine. Then finding the point at which these two kinds of intestine met, he discovered there an obvious constriction, and in the constricted mass he felt a tumour. It was therefore obvious that he had got growth and constriction in the intestine giving rise to the symptoms we had to deal with. Now this growth he removed by the ordinary surgical methods that I need not go into, closing the upper part of the bowel with a suture and fixing the lower part of the bowel into the upper by means of a Murphy's button. That was done this day week, and the patient is, so far, going on very satisfactorily. The specimen is before us: a ring of cancerous nodules surrounding and constricting the small intestine, but not involving more than an inch of the length of the bowel.

Postscript.—The patient left the hospital for a convalescent home on April 11th practically well, having passed the Murphy's button in a creditably short interval.

Papers by Guy's Men.

On Cysts of the Breast, their Relative Frequency, Diagnosis, and Treatment. By Thomas Bryant, F.R.C.S. Eng., M.Ch., R.M.I.—*Lancet*, April 28th.

Imperial Yeomanry Hospital. By Alfred D. Fripp, M.S. Lond., F.R.C.S. Eng.—*Ibid*, May 5th.

An Example of the use of the X-Rays in the Examination of Enlarged Metatarso-Phalangeal Joints. By George H. Rodman, M.D.—*British Medical Journal* May 5th.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Taylor.

Mary	38.	Tubercular peritonitis. Pleurisy.
	39.	Phthisis. Tubercular laryngitis.
	41.	Ascending myelitis.
	43.	Apical pneumonia.
	44.	Distended gall-bladder. Ascites. ? Malignant.
	46.	Secondary carcinoma in liver.
	47.	Mitral stenosis.
	49.	Carcinoma of œsophagus.
Philip	21.	Acute rheumatism.
	22.	Carcinoma of pylorus. Gastro-duodenostomy.
	24.	Typhoid.
	27.	Myelitis.
	28.	Phthisis.
	30.	Mitral stenosis and regurgitation.
	31.	Locomotor ataxy. Primary optic atrophy.
	33.	Mitral stenosis. Tricuspid regurgitation.
	34.	Phthisis.
	35.	Pernicious anæmia.

Cases under Dr. Shaw for Dr. Hale White.

Philip	1.	Lobar pneumonia.
	2.	Phthisis.
	3.	Cerebellar tumour.
	4.	Rheumatic endocarditis.
	5.	Pericarditis.
	6.	Bronchitis and emphysema.
	7.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
	9.	Lobar pneumonia.
	10.	Epistaxis. Cirrhosis of liver.
	13.	Ascites. Cirrhosis. Perihepatitis.
	14.	Meningitis.
	15.	Acute rheumatism. Mitral and aortic regurgitation.
	17.	Cirrhosis of liver.
	18.	Bronchitis.
	20.	Pleurisy with effusion.
Mary	14.	Ovarian cyst.
	15.	Cerebral tumour.
	16.	Enteric.
	18.	Chorea.
	19.	Gastric ulcer.
	21.	Mitral stenosis.
	22.	Mitral stenosis and regurgitation. Jaundice.
	23.	Pleurisy with effusion.
	24.	Floating kidney.

Cases under Dr. Pitt.

Mary 27. Mitral stenosis and regurgitation.
28. Thrombosis of femoral vein. Pyrexia.
29. Chronic tubal nephritis and cardiac failure.
30. Hemiplegia. Hysteria.
31. Perforated gastric ulcer.
33. Anæmia and tuberculous peritonitis.
35. Pulmonary incompetence.
36. Ascites and right pleural effusion.
37. Chlorosis.

Stephen 21. Hydro-nephrosis.
22. Empyema.
23. Right basal pneumonia.
24. Right pleuro-pneumonia.
26. Acute rheumatism. Mitral incompetence and stenosis.
29. Left pleuritic effusion. Tubercular.
31. Chorea.
32. Mitral incompetence and atheromatous arteries.
33. Chronic alcoholism.
34. Diabetes mellitus and phthisis.
35. Tubal nephritis.
37. Malignant disease of lung.
39. Aortic disease.
40. Pouching of lower end of œsophagus and vomiting.

Cases under Dr. Perry.

Stephen 7. Thoracic aneurysm.
8. Aortic regurgitation.
9. Malignant stricture of œsophagus. ? Secondary deposits in liver.
13. Mitral stenosis and regurgitation.

Mary 3. Aortic regurgitation.
9. Gastric ulcer.
10. Perihepatitis. Mitral regurgitation. Aneurysm of ascending aorta.
11. Myelitis.

Cot 52. Broncho-pneumonia.

In the Surgical Wards.

Cases under Mr. Howse.

Astley-Cooper 2. Concussion. Fractured ribs. Colles' fracture. Scalp wound.
11. Crushed foot. Amputation.
12. Dislocated patella. Fractured tibia and fibula.
32. Thyroid dislocation of femur.

Job 3. ? Spermatocele. Hydrocele.
4. Stricture urethræ. Cock's operation.
5. Strangulated inguinal hernia.
7. Anthrax.
9. Acute retention of urine. Suprapubic puncture.

Lydia 2. Tubercular cervical adenitis.
5. Double tubercular disease of hip.
10. Epithelioma of scar of burn.
12. Lupus of face.
13. Carcinoma of rectum.
15. Varicose veins. Phlebitis. Thrombosis.

Cases under Mr. Lucas.

Astley-Cooper 3. Ruptured urethra.
8. Ruptured urethra.
19. Fractured neck of femur.
20. Compound fractured tibia and fibula.

Martha 4. Dermoid cyst at external angular process of orbit.
7. Acute hæmarthrosis.
19. Syphilitic stricture of rectum.
21. Iliac abscess. ? Hip. ? Kidney.

Cot A. Talipes varus.
Cot B. Retained testis.

Lazarus 4. ? Vesical calculus.
7. Appendicitis.
8. ? Lipoma of neck. ? Branchial cyst.
10. Hypospadias. Stricture.

Cases under Mr. Golding-Bird.

Cornelius 3. Concussion.
7. Fractured patella.
17. Fractured femur.

Luke 5. Double inguinal hernia.
9. Extravasation of urine. Gonorrhœal stricture.
12. Tubercular testis. Prostate. Phthisis.
14. Old Pott's fracture.
20. Tubercular osteomyelitis of great trochanter.

Charity 1. Imperforate anus.
6. Strangulated femoral hernia.
12. Gangrene of foot. Amputation.
13. Fibro-myxoma of arm.
15. Compound tibia and fibula.

Cases under Mr. Jacobson.

Astley-Cooper 6. Fractured fibula. Lacerated leg. Septic arthritis of knee. Amputation.

Cornelius 7. Punctured wound in buttock. Ruptured urethra.
15. Fractured olecranon.

Naaman 3. Popliteal necrosis.
4. Venous angeioma.
6. Epithelioma of floor of mouth.
7. Epithelioma of tongue. Excision.
12. Lupus facialis.

Dorcas 6. Chronic otorrhœa. ? Cause.
10. Abdominal tumour.
12. Recurrent carcinomatous glands in axilla.
17. Spinal dermoid cyst.
18. Tubercular spinal caries.

Cases under Mr. Symonds.

Job	13.	Frontal empyema.
	14.	Recurrent gall-stones.
	16.	Cleft palate.
Lydia	19.	Goître.
	20.	Movable kidney.
	Cot A.	*Hare-lip and cleft palate.*
Patience	3.	Erysipelas.

Cases under Mr. Lane.

Lazarus	12.	Ununited fracture of patella.
	14.	Old cranial injury. Jacksonian epilepsy.
Martha	11.	Inguinal tubercular adenitis.
	12.	Congenital dorsal dislocation of hip.

Cases under Mr. Dunn.

Luke	2.	Varicose veins.
	10.	Senile tubercle of knee.
Charity.	19.	Melanotic sarcoma.
	20.	Carcinoma of sigmoid.
Patience	1.	Mammary abscess.
	4.	Cancrum oris.

Cases under Mr. Steward for Mr. Fripp.

Dorcas	20.	Varicose veins.
	22.	Recurrent sarcoma in neck.
	Cot B.	*Cleft palate.*

Some Notes on the Imperial Yeomanry Hospital.

Imperial Yeomanry Hospital,
Deelfontein,
April 9th, 1900.

Everything is going on very well with us. We have taken in 220 more patients, half of them from the recent reverse at Bloemfontein, and the other half from Naauwpoort, where the largest detachment of Yeomanry is situated at the present time. There is another large detachment at Kimberley under Lord Chesham, now made a Brigadier-General, and there are still about 3,000 at Cape Town, or there were a few days ago. Of course all these latter will be pushed up-country as quickly as the exigencies of horse-supply and transport permit, and it will not be long before the Yeomanry base camp there is reduced to some three or four hundred occupants; for I know it is Lord Robert's intention to utilise all the Yeomanry at the front and at once. By the time this letter reaches you any allusion to the news of the moment will be very stale, but of course the reverse, which has resulted during the last few days in the re-occupation of the Bloemfontein waterworks by the Boers, very materially affects the position of this hospital, for it will influence the immediate future of the campaign very much. Thus, in the first place, it will delay Lord Roberts' onward movement from Bloemfontein, and in the next place it will make it so difficult to get forward the seven miles of trucks loaded with stores now congregated at Norval's Pont, that all the material and personnel of the various hospitals which are being held ready to be shot into Bloemfontein at the earliest possible moment, will be unable to get through for some time yet, and will be unable to establish themselves in time to relieve the present state of congestion in the hospitals North of us. Those hospitals which it had been intended to thus send up are of course already packed and loaded on trucks and therefore they are useless for the present, and we find ourselves obliged to struggle our utmost to battle with the numerous cases coming down (both from the Western border and from the Bloemfontein line), for which there is no room in the already overfilled hospitals at De Aar and Naauwpoort.

I found Cape Town last week fuller than ever. Not only has there been a steady influx of men, who have come out in the hope of finding work "in any capacity" (most of them seem to think their best chance of getting up-country is to acquire the title of correspondent to some paper, however obscure), and of ladies who have come out with their husbands or to await the return of their husbands from the front; but also many officers have dashed down from the front to Cape Town for a few days change and well-earned rest. From these many most interesting anecdotes and stories of the pluck displayed by our men are to be heard.

My chief object in going to Cape Town was to establish a small hospital at the Yeomanry base camp near Cape Town for the treatment of those cases which were taken ill there, or on the voyage out, but were not suitable for transmission 500 miles up-country for treatment in this hospital. Of course many casualties of these classes arise. Indeed, it is calculated that over one per cent. of all soldiers require treatment in hospital directly they arrive in South Africa. We have accordingly started a small "detention hospital," and so as to avoid delays, we have provided some of the necessary money for its erection and equipment, but in view of the fact that it is impossible for us, 500 miles away, to take any responsibilty for the way in which this hospital is conducted, we have stipulated that it shall bear no nominal or material connection with the Imperial Yeomanry Hospital. General Wilson, R.A.M.C., the Principal Medical Officer of the Forces in South Africa, has accordingly named it the Mackenzie Farm Hospital (for Mackenzie's farm, Maitland, is the site of the Yeomanry base near Cape Town), and he has undertaken to provide the doctor, the equipment, the orderlies, and all the necessary supplies, and to be responsible for the character of the work done in it. By this means I hope that the wants of the Yeomanry, while situated at their base camp, will be more than adequately met. It is really rather amusing and at the same time embarrassing how each regiment of the Yeomanry, wherever they may be sent, are just a little hurt if they do not find our huge base hospital quite close to them. Of course we are a very large and a very immobile unit, and we had to go where we were

sent by the military authorities, but the report of the comfort of our establishment has spread throughout South Africa, and every regiment, as I said, wishes we were nearer them. Those who are at Kimberley wish that we were there; those who have gone to Naauwpoort wish that we were there; those who are at Cape Town wish we were there, and when they move up to some other advanced base no doubt they will wish we were there too. Unfortunately we are one hospital, not four or five. We have done all we can by writing and telegraphing around to meet the case, and the way that isolated parties of Yeoman are frequently arriving in our wards from various parts shows that we have been successful in making the principal medical officers of all stations understand that our wish is to get hold of every sick Yeoman in South Africa who is fit to travel to us, no matter how slight his ailment may be. We always make a point of keeping thirty beds vacant for Yeomen who may arrive unexpectedly or at very short notice.

Recent developments include the getting into working order of the laundry and of the filtering plant (hitherto we have had to boil all the drinking-water to be on the safe side). The cemetery, too, owing to the typhoid fever, is, I am sorry to say, already needed. Of course each funeral is carried out with military honours, including the "Last Post," but not including the firing of the salute, for that would be heard and understood by the other sick ones who are hovering between life and death. Poor fellows, their arduous and prolonged efforts on short rations at the front tell heavily against them when subject to a long and exhausting illness, and failure of power is apt to cut short a case, which in ordinary civil conditions would in all probability have pulled through.

Also we are beginning to rig up telephones, for the distances are considerable and all the orderlies are wanted in the huts and can be ill-spared for running messages.

Imperial Yeomanry Hospital,
Deelfontein,
April 16th, 1900.

The huts are a great success and most comfortable, but of course they render it quite impossible for the hospital to be anything but stationary. How I wish that a few hundred of the people who so generously gave their money or their work for this hospital could come and see what great good it is doing and how delighted the patients are, officers and men alike. We brought out 40 nursing sisters; now I wish we had brought out 80 or 100. We should not have found that number one too many for our hospital when quite complete. I am very pleased that the Imperial Yeomanry Hospital has been one of the first to employ nurses on a large scale. This, I think, is a great advance in the medical attendance of our sick and wounded soldiers. It has been rendered possible by rapid steamship and railway travelling, good transport of supplies, the Geneva conventions which neutralise in civilised warfare all non-combatants, and further by the fact that the modern highly-skilled nurse has grown up since the last large British war. I am sure that apart from their skill and help to the doctor they confer comfort and happiness on the patients, and I think that in the future it will be recognised that there will be plenty of scope for the nursing sister in war.

The most interesting time in our hospital is when No. 2 and No. 3 hospital trains run into our private railway siding and discharge their patients. The siding runs right into the hospital grounds, so that the difficulty of transferring cases from the carriages to the wards is as far as possible minimised. No. 1 hospital train and Princess Christian's train are at work in Natal. No. 2 brought us a load last week, and to-day No. 3 brought us 96 cases straight from the recent actions around Bloemfontein. Many of them are very badly injured. One young officer has no less than seven wounds, four made by bullets and three by bits of shell. He will, I think, recover completely, and be as good a man again as ever he was. It was, indeed, good luck that none of his wounds were serious; but it is not surprising to find his nerve considerably shaken by such an experience. Lying in the next bed to him is another officer (for we have officers' wards separated from the general wards, and as soon as the patients in them are completely convalescent we put each into a small private tent where he can be attended by the private servant who always accompanies each officer) who has been almost as lucky, for he has been shot through both thighs just below the hip, and would almost certainly have lost both his legs if the wound had been inflicted by the old-fashioned soft leaden bullet. The cases that we got from Paardeberg were not so fortunate, for they, poor fellows, all had a three days' journey in ox-wagons before they reached the hospital at the Modder river. Singular cases abound in every train-load. For instance, an officer received to-day had a bullet go through his arm and after shattering the bone escaped from the opposite side with such diminished force that it did not even pierce his sleeve, but fell down into his hand. We have also two cases where bullets pierced the skin exactly over the heart, not having sufficient force left in them to do more than just bury themselves under the skin, whence they have been easily removed.

We have always made it a rule to keep 30 beds vacant on the chance of unexpected arrivals of Yeomanry, to whose wounds it is, of course, our primary duty to minister. To-day showed how fortunate it was that we made this rule, for after taking in the 96 patients from the ambulance train, thereby filling all our beds but five, we put up extra stretchers to accommodate some of the convalescent of our older cases so as not to infringe our rule. We had no sooner done so than a party of 14 wounded Yeomen arrived and we were able at once to put them to bed.

Many of those who have supported our hospital probably hardly realise its size. Eventually we shall be able to put up as many patients as may be found in Guy's

Hospital on any day. If any of our subscribers want to realise how many patients that means they will get a very good idea by looking over Guy's Hospital some afternoon. All the equipment for the wards is in excellent condition with the exception of the wooden furniture, such as tables, cupboards, and chairs. These articles have stood the journey very badly, consequently we have a large number of breakages, and we are rather short of wooden tables, &c.

We are sending our second trainload of convalescents down to Cape Town this week for shipment home to England. We have to keep them here until we can fill up a whole train, but parties of men who are fit to return to the front are sent almost every day to De Aar, whence they are forwarded to their respective regiments.

An odd meeting took place here the other day between two brothers who had not met for months. Each thought the other was in Bloemfontein, so they were not a little surprised.

The staff of the Portland Hospital on their way to Naauwpoort got off the train that was conveying them and their hospital and paid us a visit.

We are just getting a laundry to work, and as it is to wash for 750 people a week it will have to be a large one. At present we cannot afford sheets for our convalescents, nor, indeed, do any of the medical staff or orderlies possess them. When, if ever, we have such luxuries it will mean putting through the laundry 2000 sheets a week, to say nothing of blankets, pillow-cases and smaller linen.

The same boiler that heats the water for the laundry provides the steam by which all our articles of infected clothing and bedding are sterilised, and also feeds the engine that pumps the water used for drinking purposes through the big filter-tanks.

So many people pass through by train that we often have unexpected visits from our friends and we are generally able to give them lunch or tea.

In many ways I think that good cannot fail to result from the participation in this war of so many civilians. It will quicken the interest of many people in the management of the army and the well-being of that service, while the discussion on the Army Estimates, instead of being to most people very dull, will be a matter of great interest.

We had a most successful parade service on Easter Sunday and every member of our staff had a present of tobacco to celebrate Easter day. The orderlies all were very delighted, for they have great difficulty in obtaining tobacco. They have been working very hard since they came.

A. D. FRIPP.

Royal Army Medical Corps.

"COMFORTS FUND."

The following is an addition to the list previously rendered:—

	£	s.	d.
N. J. B. Ball	0	10	0

The Aetiology and Prognosis of Epithelioma of the Tongue.

[Read before the Physical Society by Mr. F. G. Gibson, and received the Society's Prize.]

(*continued.*)

While considering the physical characters of epithelioma at its onset, it is worth while noticing the large number of cases in which the disease commenced as a fissure, or crack, or as a pimple, or white patch. I have collected my cases under various headings though I feel the classification is inaccurate, partly owing to the different terms employed by the patients, and partly to the difficulty of sifting the patients' ideas from those of the reporter. I collect the cases as follows:—

(1.)	As a crack:—		
	a. On dorsum	2	
	b. On under surface	0	
	c. On margin	5	
		—	7
(2.)	As a pimple:—		
	a. On dorsum	2	
	b. On under surface	4	
	c. On margin	19	
		—	25
(3.)	As a nodule		17
(4.)	As a blister or white patch		4
(5.)	As an ulcer:—		
	a. On dorsum	5	
	b. On under surface	2	
	c. On margin	9	
		—	16
(6.)	As a general soreness or rawness ...		22
(7.)	As an ulcer spreading quickly from a wound		3

We see then that the pimples and general rawness "have it." This is not of much value, as they are the most general terms, but they do show how small and insignificant may be the origin of a dread malady, they prove with what suspicion we should regard all chronic fissures, or pimples of the tongue between the ages of thirty and fifty; and with how little hesitation we should excise them if they show the slightest tendency to induration "instead,"—if I may be pardoned for quoting the words of Mr. Hutchinson, *B. M. J.*, 1872—"Instead of looking on whilst the fire smouldered, and waiting till it blazed up, we should stamp it out on the first suspicion. What is a man the worse if you *have* cut away a warty sore on his lip, and when you come to put sections under the microscope you find no nested cells? If you have removed a painful hard-based ulcer of the tongue, and with it, perhaps, an eighth part of the organ, and when all is done and the sore healed, a zealous pathological friend demonstrates to you that the ulcer is not cancerous, need your conscience be troubled? You have operated in the precancerous stage, and you have probably effected a permanent cure of what would soon have become an incurable disease." Unfortunately the surgeon does not

see these cases in the early stage, indeed as a rule very considerable ulceration has already taken place, the induration is becoming wide spread, and not until the fatal error of procrastination is recognised will this cease to be the case. There may have been an improvement indeed lately. Surgeons may have been inclined to run to the opposite extreme, and by operating have shortened the patient's life by a few months, but all this belongs to the chapter of prognosis.

Mr. Barker says in his paper, "As to the question whether syphilis generally predisposes to epithelioma of the tongue, it may be answered in the negative." He collects 205 cases, of whom 28 had clearly had the disease. It was doubtful in 8. Suppose he had found the same proportion of cases with a plain history of heredity, would he have dismissed them with such scant attention? Mr. Hutchinson, on the other hand, says, "The frequency with which old syphilitic sores become cancerous is very remarkable; in the tongue, in particular, cancer is almost always preceded by syphilis." There we have two equally sweeping, but diametrically opposed, statements by two eminent men. I can only suggest that negative history with regard to syphilis is generally valueless. The patient will, nine times out of ten, deny the occurrence of the disease point blank, or he will attempt to mitigate what he looks on as an offence by calling it by some more euphemistic title. He will own up to a "clap," where he will deny a chancre; he will admit gonorrhœa, but not syphilis, unless he is a hardened sinner. In my own list of cases, 19 admitted syphilis; there was a doubtful history in 10, an example being that of a man who, while denying any syphilitic history, admitted that his wife had had a similar condition of ulcerated tongue, while the patient's lung condition was diagnosed while in hospital as "(?) Syphilitic stenosis of bronchus." Seven cases had an admitted history of gonorrhœa, while 21 were emphatic in their denial, but included one patient who had had neither gonorrhœa nor syphilis, but suffered from a stricture, and a sailor who had a "scurvy tongue," but no syphilis. In 35 cases the ward clerk had not pressed the point, and this was obviously the case with the female patients, of whom one gave no history of syphilis, but suffered at the age of 40 from ulcers on the tongue, and a sore throat which disappeared under treatment; a second suffered from ulcers on the tongue, and a bad sore throat, which have recurred since but disappeared; a third had had three children, and one miscarriage, but no sore on tongue or skin disease; she however subsequently admitted to having been under treatment for two months for an ulcerated tongue, so that of my eight female cases three have a suspicious history, to say the least of it. Again, of 121 of his cases, Mr. Barker states that there was no note as to whether they had had syphilis or not, and in 35 of my 95 the same was the case. It is easy to place undue reliance on such tables, but I cannot help leaning to Mr. Hutchinson's view though I think he goes to the opposite extreme. I think it is fairest to regard syphilis as a frequent cause of a chronic indolent ulcer on the tongue, and, as such, a predisposing cause of epithelioma. Tuberculous ulceration I should look on as an equally predisposing cause, but, I imagine, tubercular deposits in the tongue are very rare compared with the breaking down gummata; six of my collection give a definite tubercular history, which is about the normal proportion of any 95 cases; eight had a gouty family history; and one case had had what his doctor describes as a "gouty tongue," but which from the recurrent ulceration seems to have been suspiciously like syphilis. Gout may have some connection with a chronic glossitis in causing deposits of tartar on the teeth, while the easily ground down, or broken, teeth described as "gouty," would be particularly liable to act as a source of chronic irritation.

I shall conclude my remarks on the ætiology of the disease with an examination of the histories of heredity, or family liability to cancer. Of this Mr. Barker takes no notice, although his list of 60 cases includes 2 with probable evidences of a hereditary taint, and 2 with doubtful histories. In my list of 95, 8 give a definite family history of cancer, 2 of remote history; of the former I may mention No. 67, whose brother died of cancer of the stomach; No. 54, whose brother died of cancer of the tongue; and No. 85, whose mother, father, and two sisters are stated to have died of "cancer."

Another interesting case is that of No. 52, who had her breast removed by Mr. Hilton in 1858 for a supposed malignant tumour which was found not to be malignant after operation. At the age of 72 she noticed a small pimple on the left side of her tongue which she thought due to the irritation of her false teeth; the left half of her tongue was removed by Mr. Golding Bird and found definitely epitheliomatous, but the glands subsequently became infiltrated and she died eleven months after the original lesion was noticed.

Next as to the question of prognosis. Epithelioma is eminently a fatal disease; if left to itself the growth rapidly advances along the succulent tissues of the tongue, floor of the mouth, epiglottis, and tonsils, and death soon ensues. In a large proportion of cases the fatal termination is due to exhaustion, the result of pain, distress of mind and difficulty in taking food; in some to septic pneumonia, the result of inhaling the fœtid discharges from the mouth; a few die early from hæmorrhage when the ulceration opens up the lingual, or the carotid artery as is shown by case No. 21.

Death may occur from asphyxia, either owing to implication of the epiglottis, and its folds, causing œdema of the glottis, or a mass of enlarged glands in the neck may press on the trachea, and cause suffocation.

Is it then expedient to operate? Certainly, if there is the faintest chance of prolonging the life of the patient, or relieving his intolerable distress during the few remaining months of his life.

(*To be continued*).

Passim.

We have been asked to express the gratitude of Mrs. Davies-Colley to the students of this hospital for the expressions of affection and sympathy which they extended to her in her bereavement. It is her wish, too, that it should be known that the letter which Mr. Davies-Colley wrote acknowledging the receipt of the Illuminated Address, was written on the eve of his death, and was the last occasion on which he took pen in hand. This letter, published in our last issue, is a striking demonstration of the fact that he retained his clearness of intellect to the last, and only lost his mental vigour with consciousness itself.

Last Friday week, the 18th inst., to be accurate, was heavy with many surprises. The sun had played his proper part during the day, but had left the world to a night which had strayed from the November pigeon-hole. Still a bright fire and an excellently seasoned pipe gave promise of a peaceful and scholarly evening, and we sat down to the culture of mind with the ceaseless diapason of old London as a mental background. But suddenly the note changed, grew louder, and of higher pitch. Soon the elements of human voices were detected in the murmur, and we learned that men, great bodies of men, were cheering, madly cheering. Presently the river steamers and locomotives took up the call, and bayed or bleated pæons of victory, and then doors were hurriedly opened everywhere and we all streamed out, citywards. There was no more work for that night; only cheers, for the Queen, for Bobs, and for B.-P., and then for the Queen again. Flags sprang up everywhere and were waved by everyone; entire strangers walked arm-in-arm and sang patriotic songs with scant reference to time and key, and the figure of Thomas Guy, which had waited for weeks in silent expectation, was seen wildly gesticulating with a Union Jack in each hand.

The next day bunting was flying everywhere, and tiny flags hung from many of the hospital windows. There is no flagstaff at the hospital, and of course no official flag of any kind. But a small band of enthusiasts procured a huge white ensign and then set about hanging it out from some conspicuous spot. The central ventilating shaft of Hunt's house is an ideal position for a flag, but it was found practically inaccessible. So the South West Tower of the Medical Buildings was chosen as offering both reasonable means of access and also a good field of vision. The approach, however, contained certain unique dangers, and it was only by looking straight to the front and turning the head neither to the right nor to the left that the enthusiasts reached the tower in safety. A seventeen foot flag-staff was then lashed to a scaffold pole, and the two together were hoisted over the balustrade, with the signal halliards running free through the end of the staff. And when the mighty flag broke out clear on the breeze a roar of welcome went up from a big crowd which had collected below, and everybody went away and told his friends that the flag was flying there solely through his own individual efforts.

Fortunately, perhaps, for the peace of mind of the Commissioner of Police, there are no organized demonstrations of medical students in this country. The insular spirit invades the individual hospitals and prevents any effective co-operative movements. A few of the younger Guy's men, about sixty in all, left unostentatiously in the morning with hand-flags and other emblems of loyalty, and gathering courage from the fleeting hours, returned to the hospital about mid-day as a flag waving, cheering procession. Halting at Guy's statue, they sang as much of the National Anthem as they could remember, and then advanced on the hospital. The Treasurer was skilfully outflanked and greeted with shouts of "speech," to which request he replied with great good humour and commendable brevity. Finally those of the procession who were able to articulate, shouted away the remnants of their voices and the crowd adjourned to lunch.

Soon after this the Matron, Treasurer, and Superintendent, were observed walking together in the direction of the Nurses' dining hall, from which, after the lapse of some minutes, issued the sound of female voices singing "God save the Queen," after the best traditions of the Nurses' Choral Society. Mr. Bonsor had made a neat little speech in which he referred to the universal rejoicings in London, and had awakened a responsive chord in his audience which was further agitated by Dr. Perry's little Union Jack. Finally, in the hospital itself, the Superintendent had given permission to the patients in the male wards to smoke, and pungent clouds testified to their appreciation of Baden-Powell's victory.

IT was an unfortunate exhibition of routine which deprived Surgeon Beadnell of his just connection with the "Powerful" brigade. By a rule of the service the order which invalided him home, removed also his name from the ship's books, and although he passed through the campaign with the ship's crew, and was twice mentioned in despatches, yet he was not a member of H.M.S. "Powerful" when the receptions were held. But although he was thus deprived of the more ephemeral rewards which have fallen to the share of the Naval Brigade, we notice with pleasure that he has received well-merited promotion, and has now the rank of Staff-Surgeon. We offer him our heartiest congratulations.

THE *Newcastle Evening Leader*, of the 12th inst., contains a portrait-sketch of Dr. Dennis Embleton, one of the oldest medical practitioners in the kingdom, and a student of the once conjoined schools of Guy's and St. Thomas' Hospitals. Dr. Embleton is an M.D. of the Universities of Durham and Pisa, and is well known in Newcastle as a keen student of literature, and as a natural historian and antiquarian of no little repute. He is consulting physician to the Royal Infirmary, and a prominent member of the Northumberland and Durham Medical Society. His name is known in literary circles chiefly in connection with his works in collaboration with Mr. Hancock on professional subjects, and as author of a "History of the Newcastle School of Medicine," and "Newcastle Medical Society One Hundred Years Ago." He is probably the greatest living authority on the antiquities of Newcastle.

THE Birthday Honours are as usual fraught with disappointment, both to the individual and to the collective bodies. The sciences are again left severely alone, and the value of major honours worked out by the convenient standard of the existing currency. Minor honours are apparently bestowed on other than political claimants, and we find among the list of new C.B.'s the names of two old Guy's men, Surgeon-General Muir and Colonel Connolly, late Surgeon-Colonel A.M.S. To the present generation Colonel Connolly will best be known as the holder of the 100 yards United Hospital Athletic Club record. All Guy's men will join in congratulating General Muir and Colonel Connolly on their well deserved honours.

A LARGE attendance of men greeted Mr. Jacobson when he took the chair, for the first time as President, at the general meeting of the Football Clubs. The business transacted was confined to the election of officers and the abolition of the "Honour Cap," an invidious distinction now happily defunct. Before proceeding to public business the chairman made a graceful allusion to the profound loss which the hospital had sustained in the death of the late President, Mr. Davies-Colley. In the course of the business of the meeting, Mr. Jacobson shewed that he possessed the rare gift of getting straight to the hearts of his audience. He replied to the vote of thanks accorded him for occupying the chair in a quaintly humorous speech, in which he dealt with his own athletic achievements, and referred to the possible exploits of a certain holder of his name. In the Rugby Football Club. Mr. Cutler succeeds Mr. Mullins as captain, and Mr. Wall follows Mr. Gibson as secretary. In the Association Club Mr. Robson is captain *vice* Mr. Wiltshire, while Mr. Wiltshire takes the post of secretary vacated by Mr. Robson's election to the captaincy. We venture to think that the general meeting shewed a very excellent choice in its election of officials.

THERE is at hand the report for the year 1899 of the Medical Sickness and Accident Society. The chief points of interest about the report are, firstly, the sound financial condition in which the society is placed, as is shown by the fact that the increase in funds for the year is nearly six thousand pounds, while the amount disbursed in meeting sickness and accident claims shews an increase of only thirteen hundred pounds on that of the previous year. Secondly, the working expenses of the society are kept at less than five per cent. of premium income, and finally the membership roll of the society is steadily increasing. The society is flourishing, and considering the useful purpose it subserves, deserves to flourish.

WE have received a circular from the Queen's Westminster Rifle Volunteers (13th Middlesex) dealing with a new company to be called the Royal Welsh Fusillier Company, and to be recruited from London Welshmen. The hon. secretary of this new company, Mr. D. T. Williams, of Queen's Hall, Buckingham Gate, London, asks us to give publicity to the scheme in order that he may obtain recruits from members of our Medical School. The great majority of men at Guy's who go in for volunteering are members of the Artists R.V., the next in order of strength come the London Scottish and

the Devil's Own. Still, there may be some men who would prefer to join a Welsh company and —an additional advantage, perhaps—wear a slouch hat on parades. These, then, should apply to Mr. Williams at the address given above; either by letter, or personally on Mondays.

There is a story going the rounds anent a certain London hospital where asepsis is practiced on the most approved principles. Curiously enough, however, the cases did not do as well as the care bestowed on them merited. The germ leakage was not obvious but was none the less real, and the resident officer suffered much mental anguish and discomfiture in his attempts to solve the problem; finally he turned his attention to the sterilized pads, with feelings almost as if he were committing sacrilege. He placed a bit of ordinary wax candle of low melting point among some pads and sent the lot to be sterilized. They were returned in due course after exposure to super-saturated steam for so long, according to the rules and regulations, but on examination the candle was found to be free from the slightest distortion; in fact, was in the same condition as before sterilization. They are giving antisepsis a trial now.

A propos, one cannot help feeling that there is room for improvement in the garments worn at operations. The most familiar sight is that of a bare-armed, macintoshed man, enveloped in sterilized, lysol-soaked overalls. On rare occasions one sees the strictly aseptic overall; that is to say, a dry sterilized blouse or "redingote." But we never see an operator nor his assistant wearing any head covering, although it is impossible to prevent the hair of a dresser's head occasionally coming into contact with that of his surgeon, to the probable detriment of the wound. Sterilized brewers' caps would—applied properly—prevent all risk of spores being dusted from the head into the wound, and would also add to the æsthetic value of the operators. To those who prefer the wet sterilization methods we would propose the use of a hard felt hat, boiled, and wrung out of lysol. There is no charge for this suggestion.

We regret that it has been found impossible to issue with this number the photograph of the late Mr. Davies-Colley, of which we gave notice a fortnight since. The process by which the portrait is reproduced will not admit of the slightest hurry; we have no alternative, therefore, but to postpone the issue of this supplement for yet another fortnight, with, however, reasonable hope that further delay will be unnecessary.

From the Gazette's Special Pathologist.

NOTICES.

X. Y. Z., Hastings.—No tubercle bacilli were found in the sputum.

H. V. H., Wanstead.—*Microscopical examination.* The centrifugalized deposit is only small in quantity and consists chiefly of pus. There are a few red blood discs with it, and some minute crystals of calcic oxalate. A small number of cells like those from the renal pelvis were found, but no casts at all were detected. This is remarkable in view of the diagnosis and persistence of the complaint. Also the number of red blood discs is no more than is usually met with in the presence of pus, and if there is a calculus in the situation suggested it is customary to find more blood than is present in this specimen.

PATHOLOGIST.

Appointments.

NAVAL AND MILITARY.

Captain S. H. Burnett, I.M.S., Bombay Establishment, has been appointed Personal Assistant to the Surgeon-General with the Government of Bombay.

Dr. H. Bowen Perkins is appointed Surgeon-Lieutenant in the 15th Middlesex Rifles.

Surgeon Charles Marsh Beadnell, R.N., is specially promoted to be Staff-Surgeon for services in South Africa.

Surgeon Harold G. T. Major, R.N., is appointed to the *Ramillies*.

Captain William G. Beyts, R.A.M.C., from the Seconded List, to be Captain, *vice* M. L. Hughes, killed in action. Captain Beyts was seconded for service as surgeon to the late Sir W. Lockhart, Commander-in-Chief in India.—*British Medical Journal.*

Mr. F. H. Hardy, M.R.C.S. Eng., L.R.C.P. Lond., Guy's Hospital, who has been serving under the Foreign Office in Central Africa, has been nominated by the Secretary of State for War as a Surgeon-on-Probation.—*Lancet.*

Surgeon-Lieutenant R. G. P. Lansdown, 1st Gloucestershire Artillery, is promoted to be Surgeon-Captain.

Surgeon-General Henry Skey Muir, Deputy-Director-General, Army Medical Staff, and Dr. Benjamin Bloomfield Connolly, have had the distinction of the Companionship of the Bath conferred on them in the recent *Gazette* announcing the Birthday Honours.

Obituary.

J. M. C. Davies-Colley,

M.A., M.C., F.R.C.S.

There is a great difference between the loss of a member of the Staff by resignation, and by death, and that which we have just sustained touches us the more deeply when we realise that for some months Mr. Davies-Colley knew the fatal character of the illness, and yet continued to discharge all his duties with that unfailing regularity for which he was so celebrated.

The chief aim of this sketch will be to recall to the memory of past students the part that Mr. Davies-Colley took in the work of the school and hospital, and thus to make others realise how great a loss we have sustained.

The tall, big figure, passing with long stride down the colonnade, acknowledging the greeting of colleagues with an unvarying and genuine smile, that of his old house-surgeons and dressers with a more than friendly recognition, and that of the junior men with short and quick nod of the head, will long be remembered.

Mr. Davies-Colley came to Guy's, after taking a good position at Cambridge, for he was a Scholar of Trinity, and took a double degree, being a Wrangler and head of the Second Class in Classics.

The men of 1871–3 will recall Mr. Davies-Colley as demonstrator of anatomy, while many of this period are indebted to him for the voluntary help he gave them for the old Preliminary Scientific.

The men who entered in '71 and several later years will recall him best in the classes he gave for the Final College. It was, I think, Mr. Davies-Colley who established these classes—at least, he placed them in a much more important position. He gave us examination papers regularly, marked with the greatest care, and placed the class in order of merit. If a man was advised to go up he rarely came back, whereas if Mr. Colley opposed the trial, disaster was not unlikely to follow. In the viva voce at these classes many will recall how we sat round one of the tables in the old histology room, while he asked questions on the specimens. What excellent teaching it was—each question carefully put, and the minutest accuracy insisted upon in the reply. I recalled these days to our lamented colleague, and to my astonishment he produced a file of old papers, and there was my own name and the marks received. In meeting men of this time—for instance, Withers Green, Shadwell, Oram, and many others, we talked over the admirable help we received in these classes, and it was a great pleasure to carry these tributes to Mr. Davies-Colley. He was surprised at the widespread appreciation that his teaching had obtained, and received the messages with much pleasure.

Then, again, he frequently attended the examinations in those days, to observe the style of question, and gave us the benefit of his observations. He was very jealous of the success of the men, and took the greatest pains to prepare the class, and some in consequence resented his advice to wait another three months, but he was nearly always right.

Of his lectures in anatomy I can say little, for I never had the advantage of attending them. That they were accurate, well illustrated, and that he never missed one there can be no question.

One next meets Mr. Davies-Colley in the wards, and here one appreciates his great power. When house-surgeon and registrar I remember his opinion being sought in many of the difficult cases, and later, both in hospital and private, his advice was often asked. Many generations of students will recall his ward teaching. Sometimes, no doubt, he was a little too minute, but this was the result of his endeavour not to forget the patient while he instructed the student, and of insisting upon accurate records being kept. He took great pains with the teaching at these visits. I have found him during the morning preparing the questions he intended to ask at his visit in the afternoon. To the very last he kept up his teaching, always devoting the greater part of the Monday and Thursday visits to the wards.

As President of the Football Club, he took a keen interest in the Cup Matches, and was invariably present at the final.

As a surgeon, few can show a record to equal in success that which Mr. Davies-Colley achieved, unless it be Mr Howse. He took up Lister's method after its introduction into Guy's by Mr. Howse. It is, indeed, our present senior surgeon to whom belongs the honour of introducing antiseptic surgery in London. In 1874 Mr. Davies-Colley, then with Mr. Howse, assistant surgeon, was obtaining remarkable results, and it was an evidence of his advancing tendency that he employed all the new methods, and of late practised the aseptic method.

A bolder surgeon there could not be. He carefully thought out every detail of a new operation, and seldom, if ever, was he in a difficulty. In the surgery of the joints, in large operations for cancer of the breast, in the extensive removal of malignant disease of the tonsil and tongue, no one could have been bolder and at the same time more accurate. The success which attended these operations in his hands was of a very high order.

Mr. Davies-Colley was a man of large mental calibre, for not only had he a fine memory, a clear judgment and a logical mind, but he could look at a question all round, and take a broad, comprehensive view. He would often throw an entirely new light on a question, for he had the gift of originality. These grand qualities proved of inestimable service to the school, and in consequence he served on nearly all the important committees. No question was likely to leave his hands without being thoroughly threshed out.

Personally I do not believe he ever had an enemy, and yet he could be severe, but never where he was himself

concerned. When in opposition it was the question he attacked, never the individual, so that he won the esteem and regard of everyone. He set a fine example of duty; nothing I believe could tempt him to forego a lecture—as an old fellow student of his once said to me—"temptation could not approach him."

To me, as his assistant surgeon, he was most generous; for eighteen years we worked together, and his one idea seemed to be, to take more than his share of the hospital work. Two occasions must be mentioned—one Easter he suddenly asked me if I would remain on duty as he proposed going away. It so happened that I had hopes of taking a holiday myself, and though at once assenting he must have noticed a shade of disappointment, for he came back and asked me if I intended going away, and at once offered to remain. We, however, both went away as the wards were quiet.

Again, last December—it was the 10th, I think—he knew that I was projecting a longer holiday than usual, and when some difficulty arose in my obtaining a substitute he at once offered to postpone his own holiday. And little I knew then, what he, alas, too well knew, that the span of his life was almost measured. When I returned on January the 18th, to find he had resigned, the realization of the full measure of this self-sacrificing generosity was almost overwhelming.

It would require a more eloquent pen than mine adequately to set forth the many noble qualities of this great man. I have endeavoured to recall to his old pupils something of what he did for us in the early seventies, and to exhibit his character to those who knew him less well than some of us. The Hospital never has had, and never can have, a more devoted Officer, nor the School a Teacher with loftier views of his duty.

Mr. Oldham, of Brighton has sent, at my request, the following sketch, which will be much appreciated by the men of his time, as well as by all:—

"I entered Guy's at the same time as Davies-Colley, and very early formed a great friendship with him, so much so, that we lived together, sharing the same rooms, on and off, for some four or five years.

"He was a thoroughly industrious student, looking into and weighing everything carefully *himself*, and in a high degree indisposed to accept 'Authority' on any subject whatever.

"His powers of memory were very great, and as he was a singularly rapid reader, with a strong grasp of whatever lay before him, he was able to 'get up' any subject in an incredibly short time, and remember it.

"He was, as you know, an admirable Greek, Latin, and English scholar, with exceptional power of quotation from any of the three languages, upon occasion.

"I believe he was ninth for the Cambridge boat of his year, failing to get into it owing to some fault of form. He was a very powerful and untiring man in physical exercises, such as football, walking, skating, &c.; cricket, I think, he had never played.

"His temper was singularly easy and equable, and he possessed a very good, but not obtrusive sense of humour, combined with a certain homely north-country shrewdness.

"He was slow to anger or indignation, both however being aroused somewhat easily at any mean or despicable act. His sense of justice was a very marked feature in his character. His mind was remarkably well balanced, and he carefully and laboriously sought out every tittle of evidence from which to draw his conclusion, holding his judgment meanwhile severely in restraint.

"It would be impossible to find a gentler, more unselfish and considerate man to live with, than he was, and his patience and forbearance in all things were great. And, I may add, we never 'had a word' in our lives.

"He was an abstemious man, but a great smoker in his student days, and used to colour his meerschaums with great and rapid success, of which he was humorously proud.

"But, when all is said and done, *far and away* the main feature of his character, was his absolutely flawless integrity. It would seem as if temptation to turn to the right hand or the left, deliberately passed him by, as if success in attacking him was hopeless, so straight and simple was his course in every phase of life.

"He was very happily married (I was his 'best man') to Miss Turner, the then Treasurer's daughter, and was always full of his children and their learning, pursuits, and successes."

CHARTERS J. SYMONDS.

The Eleventh Plague.

(Mr. Frederick Treves made some very true and pertinent remarks anent women and the services. Mr. Treves is world-renowned as a surgeon for his skilful work on the vermiform appendix).

A plague of women, yes, Sir Treves,
Too true! you should be knighted
For setting out before the world
A wrong that should be righted.

For everywhere—on every side—
In every ship that floats,
One influence is paramount,
The Admiral's petticoats.

It's also just the same ashore,
And, if you'd be promoted,
For playing lap-dog to the Col-
Onel's wife you must be noted.

I hope your word, Sir Treves, may lead,
In this to some reform;
That we may cut this evil out,
As you, the vermiform.

G. S.

With the Army Medical Corps in South Africa.

(BY OUR SPECIAL CORRESPONDENT.)

(Published by permission of the Director-General of the Army Medical Service.)

SS. Nile, nearing Capetown,
Sunday, April 1st, 1900.

The voyage out on this ship with 1500 troops on board has been interesting by reason of a severe epidemic of pneumonia, which has caused considerable trouble. There have been twenty-one cases, the first seventeen being all in men of the East Yorkshire Regiment, which was suffering severely from influenza at Aldershot during February, and had lost two lives from severe cases with consolidation of the lung. They must have brought the infection on board with them, and the epidemic assumed a most virulent form. The local signs were considerably less than usual in proportion to the general signs, and were less commonly confined to the base of the lung, several begining with severe gastric pains and vomiting, and the pneumonic signs developing along the interlobar septum or in the upper lobe. Five of these cases became delirious, and three have died from heart failure after their temperature had remained steady between 103° and 104° for some days.

Treatment has been difficult, as the hospital, though amply fitted for the usual work on board a transport, was not fully enough stuffed nor stocked for so great a strain. There was difficulty in putting on ice-poultices and fomentations regularly, although the pleurisy was frequently severe; there was a dearth of thermometers when the non-official thermometers had been broken, and there was a drug-famine, the giving out of the digitalis being especially serious. It is fortunate that the sergeant of the Volunteer Medical Staff Corps, the civilian compounder, and the orderly did not break down; the atmosphere in hospital through the tropics being most oppressive.

There has been more than the usual run of minor complaints, diarrhœa and colic (owing to something in the food) with especial prevalence amongst the officers. To this may be added the effects of inoculation against typhoid fever, to which nearly all the officers but only a few of the men have submitted themselves. The inoculation is performed at four or five in the afternoon. After dinner the site of injection in the flank becomes tender and swollen and by midnight the least movement of the side is painful, while at the same time there is slight pyrexia and sometimes malaise. After a more or less restless night the general condition is usually healthy again in the morning; but the side is extremely tender and often incapacitates a man from duty for one or two days, clearing up entirely within a week. There have been no serious results.

As a point of interest, the weight of fifty men, half a company of the East Yorkshire Regiment, was taken on the tenth and again on the seventeenth days of the voyage. There was so slight a difference in total weights, four pounds increase, as to be within the range of error of the experiment; and the troops may therefore be said, when once settled down to the voyage, to be about retaining their weights. In fact, in the absence of any beer and in the presence of physical drill every other day the men are being kept at the right level of health. More could not be required.

The medical staff on board consists of three civil surgeons under a major of the R.A.M.C., the regimental officer attached to the East Yorks for the campaign. Your correspondent's colleagues are both attached to No. 10 General Hospital, and both had part of their training at Guy's,—Mr. M. W. Renton, C.M., M.B. Aberdeen, and Mr. G. Grace, who came to Guy's from Bristol in 1892. The civil surgeons have been engaged in giving ambulance lectures to the men, one company each afternoon, for an hour at a time. This has just been long enough to point out the heart and a few chief arteries in ink on one of the screens, to make them all feel each other's pulses, and stop the brachial and femoral artery; to give a demonstration on the use of the field-dressing and of improvised splints; and to teach every man how to carry off another on his left shoulder, leaving his right arm free to use his revolver.

The officers have also had a course of three lectures. It will be interesting to hear the results of the teaching in action.

In the Bloemfontein Mail Train,
Between Colesberg Junction and Norval's Point,
Sunday, April 8th.

Your correspondent has again landed in South Africa, and finds but little visible change during the two months he has been away. Table Bay is fuller of ships; the hospitals at the base are larger and more numerous; a complete system of military society has grown up in Cape Town around the chief hotels; and the departmental officers are feeling the stress of business very heavily. Perhaps the most thankless task of all falls on the Army Pay Department, whose officers have been working ten hours a day and even on Sundays since they landed with us in November, without even the public recognition which is accorded in Parliament and the Press to the other departments. Last month the office in Cape Town actually paid out £1,400,000; and when it is understood what a vast amount of correspondence take place over a few shillings, the labour employed in paying-out and accounting for a million and a half pounds is hardly conceivable. It is to be hoped that the health of all these "office-wallahs" in Cape Town will be equal to the strain put upon them, not only now but for the months that must ensue before the end of the war.

In the medical offices as elsewhere things are simply going on as best they can, under continual pressure, with constant demands for more men from the front, and with a thin stream of service-officers and civilians

trickling out from home. No one can say they are now understaffed at Wynberg, where in No. 1 General Hospital there are forty nurses and fourteen medical officers for ward-work, apart from the officers in charge. They have had a considerable number of enteric and other cases from Ladysmith and convalescents from hospitals up the line, and from off the transports; but they are never likely to have the serious work experienced after Lord Methuen's battles, now that there are several hospitals up country at advanced bases.

Your correspondent is at present travelling in a first-class carriage, which he shares with one of the consulting surgeons, on the way up to Bloemfontein, to be attached to a field hospital. Not having had an opportunity of seeing anything worthy of record, he encloses instead a graphic account of the battle at Paardeberg Drift, from the hand of Dr. H. J. Starling, who is attached to the 13th Brigade, F.H. The 37,000 troops engaged in the famous march are now for the most part at Bloemfontein, where, unfortunately, the waterworks are still held by the enemy, and there is a considerable epidemic of enteric fever, for which 500 beds are available. Mr. Watson Cheyne and Mr. Kendal Franks are with Lord Roberts, attached to the headquarters' staff, and living in President Steyn's beautiful house. Mr. Cheatle is at Kimberley, where there are some 200 or 300 beds available, and more may of course be required when an advance is made for the relief of Mafeking from this side. But it is an extraordinary thing that with all the shelling that took place in the siege of Kimberley our total loss from shell-wounds was only 15 killed and 30 wounded.

This train passed in the night the Imperial Yeomanry Hospital near De Aar; and we breakfasted at Naauwpoort, where No. 6 General Hospital is established and has nearly 600 beds filled with medical cases and a few casualties from the Free State. In the advance from the Free State Capital, Bloemfontein itself is sure to be the chief advanced base for medical as well as other purposes, while Kimberley is the advanced base on the western railway.

This journey has been full of interest, leaving Cape Town on Friday night at 9, passing through Paarl, Maggersfontein (where General Wauchope was buried), Bearfort West and Victoria West, in all of which places there has been excitement and rumours of disaffection from time to time; to De Aar, where the Free State trains leave the main Cape to Cairo line; thence eastwards to Naauwpoort, where we turned again to the north, while part of the train went off south-east to East London. Since leaving Naauwpoort we have passed through Arundel, Rensburg and Colesberg Junction, and seen with our own eyes the low-lying hard-outlined kopjes rising like mud-pies straight out of the veldt, on which the Boers were for so long held in check by General French's cavalry division. Even now we may be "held up" at Springfontein. This letter is posted from Norval's Pont, where many cameras are being levelled at the mangled remains of the old bridge. The indescribable desolation and barrenness and the utter silence of the great veldt, better imagined than described, is now at an end. We are entering the Orange Free State.

Osfontein Farm,
Orange Free State,
March 4th, 1900.

You will be probably much surprised at hearing from me in this direction. The fact is I came out arriving in Cape Town on February 6th, with No. 6 General Hospital, and was transferred at twenty-four hours' notice to the 13th Brigade Field Hospital, 6th Division, S. A. Field Force.

I have been with the 6th Division right through; the twenty-seven mile march from Reit River to Klip Drift, the subsequent fight at Klip Kraal, and the big fight at Paardeberg Drift on Sunday, February 24th. On the last occasion our hospital arrived at the scene of battle about 9 a.m., having marched since 4 a.m., and we were ordered to pitch tents at a place far too near the firing line. The dust was pitching up prettly frequently around us from the Mauser bullets at 1500 yards range, and just about luncheon time, when we had Generals Hector Macdonald and Knox and about seventy patients in, they turned the Vickers-Maxim gun (commonly known as the pom-pom) right on to us. These guns fire a series of six one-pound percussion explosive shells, and are uncommonly disquieting, to such an extent that every patient who could limp or hobble left, including the two generals who departed in Cape carts to a more secure position. We had to stick the fire till 5 p.m. as no ambulances were to be had, and we could not shift the bad cases. Luckily no one was injured, although we had eighteen shells in the camp, and the tents were perforated in many places by the bullets. The new transport arrangements have entirely disorganised the medical arrangements. The bearer company of a brigade have only two instead of ten ambulances; we are allowed only four tents and an operating tent instead of twenty-five, consequently the wounded were left for many hours on the field, and when they were brought in they had to lie in the open on the ground. Our staff consisted at this time of one Major, R.A.M.C., and another civil surgeon and myself. The major, of course, was taken up nearly entirely with official work, and so the heavy work of dressing about 250 cases (within about ten days) was left to the two civil surgeons, and we had to operate and do everything ourselves. I have never before had so much hard concentrated work in my life. As soon as it was possible we began to shift the wounded in convoys of springless buck wagons back to Modder River and thence to Cape Town, the journey to Modder River being about thirty-five miles, so you can imagine the discomfort. What strikes one the most in regard to the wounded is the marvellous escapes they have and the rapidity with which the wounds heal; excepting, of course, the frightful wounds produced by the sporting or elephant bullets and the dum-dum. These latter produce the most ghastly results, shattering bone and tearing muscle. I feel myself tremendously in luck in securing

a field hospital, seeing that I did not apply until after my M.D. result was out. I have seen Stamford several times; he is in a mounted infantry regiment. We get no news here and are absolutely ignorant even of what is going on around us. At present we are on half rations of groceries, three-quarters of a pound of biscuit and one pound of fresh meat a day. Such things as bread, milk, tobacco and newspapers have not been seen for the last three weeks, so you see we are campaigning in earnest. A post came up to-day, but of course no letter for me, so I suppose they have gone astray. Our mess-stores are finished and we are raising heaven and earth to get some more up, but the ordinary supplies for the troops are so enormous that little or no private stores can get up.

I suppose we are on our way to Bloemfontein, but as usual do not know. I hear you can get bread there, so the sooner we arrive the better. H. J. S.

Nursing News.

MATRON'S OFFICE.

On May 19th, Nurse Lane (Head Nurse in Luke ward), left the hospital at the end of her three years' training. Nurse Grasett (Head Nurse in the Surgery), was transferred to Luke ward, and Nurse Potter (Head Nurse in Bright ward), was transferred to the Surgery on night duty in her place.

On May 25th, Nurse Andrews (Head Nurse in Dorcas Ward), left the hospital at the end of her three years' training to take up private nursing work at Guy's Institution. Nurse J. Hughes (Head Nurse in the Out-patient department), was transferred to Dorcas ward, and Probationer A. Allcock has been appointed Head Nurse in the Out-patient department in her place.

Hospital for Consumption and Diseases of the Chest, Brompton.

SUMMER SESSION, 1900.

LECTURES AND DEMONSTRATIONS, WEDNESDAYS, at 4 p.m.

May 30th, "The Early Diagnosis of Pulmonary Tuberculosis," Dr. Green. June 6th, "The Dynamics of the Circulation in Disease," Dr. Maguire. June 13th, "Mediastinal Growths," Dr. Perkins. June 20th, "Clinical Varieties of Phthisis," Dr. Horton-Smith. June 27th, "Thoracic Aneurysm," Dr. Fowler. July 4th, "The Forms of Dyspepsia in Pulmonary Tuberculosis," Dr. Schorstein. July 11th, "Auscultatory Percussion as a means of Diagnosis in Thoracic Disease," Dr. Habershon.

The lectures are free to all qualified medical practitioners, and to students attending the practice of the hospital.

Guy's Hospital Dental Society.

SOME ASPECTS OF ANÆSTHESIA.

(*Concluded*).

In the short time at our disposal it is quite impossible to describe all the apparatus that is in common use, nor would a verbal description be interesting if given. I have brought a few inhalers for you to examine for yourselves, feeling sure that five minutes' practical investigation is worth more than half-an-hour's detailed explanation. You will find the following on the table when you come to look at them in a few minutes:—

1. Clover's inhaler, which may be used for giving ether alone or preceded by gas.
2. The simple form of nitrous oxide inhaler in common use.
3. Two inhalers (Hewett's and Rumboll's) for the administration of nitrous oxide combined with various quantities of oxygen.
4. Marston's terminals.
5. Flux's open inhaler.

There exists a law in one of the States of America, which makes it illegal for anyone to administer an anæsthetic to a patient without the presence of a third person in the room. While it is unnecessary to emphazise the importance of this precaution to the gentlemen here this evening, it may not be amiss to consider why such a course is advisable.

The dental surgeon who both administers the gas and performs the operation, necessarily wastes a few valuable moments in removing the face-piece and in taking up the forceps. This precious time is saved if he has an anæsthetist. And more than this, supposing an accident occurs such as a tooth passing into the larynx, he is placed at a great disadvantage if he be without assistance. A third potent reason for not undertaking the whole work oneself is that accusations of assault, though quite groundless, may be brought against one if the patient is a female. By having someone present to administer the anæsthetic he protects himself against each of these eventualities, and such a precaution will not only give him a sense of security but will also add to the confidence and well being of the patient.

It is very desirable that the patient should be given a few simple directions before being admitted into the operating room. A heavy meal immediately before the operation is to be avoided. A good breakfast at eight o'clock, if the anæsthetic is to be administered at noon, would be quite admissible. The clothes must be loose, especially those covering the neck and chest. Tightly laced corsets, always an abomination, are doubly so at such a time. The bladder and rectum must be previously emptied. While the patient is making the final arrangements in the ante-room, the anæsthetist and surgeon get everything ready that will be required for the operation, so that the patient may not be forced to sit in the chair and wait while the apparatus is being adjusted. The bags for the gases must be full and all

the instruments for emergency as well as for the operation close at hand; *i.e.*, mouth props, Mason's gag, tongue forceps and tracheotomy case, and a few nitrite of amyl capsules.

The patient sits in the chair and is made quite comfortable, any position of strain being avoided. The head rest is so placed that the neck is in the same line as the body, and the head neither bent backwards nor forwards. The inclination of the chair should be almost upright, as the anæsthesia is more satisfactory if induced in this position. Should it be necessary to place the patient in a reclining attitude for operative purposes this may be done just before the removal of the face-piece. A substantial mouth-prop is inserted between sound teeth, if such be standing in a convenient part of the arch. It is not wise to place it between solitary teeth as such may be easily dislocated by the great muscular action which is sometimes brought into play. The room must be kept quite quiet during the administration, otherwise the slightest noise may set up a train of psychological activities which may leave in the mind of the patient some unpleasant recollections. The face-piece is then applied, and pure air alone is inhaled for a few seconds. Should the patient be of a nervous disposition it is advisable to show her how to take the breaths. They must be long, deep and regular, and till they show this character the anæsthetic must not be turned on. A good motto to observe when dealing with nervous females is the same that should always be remembered in the treatment of hysteria—"Suaviter in modo; fortiter in re."

Sometimes it is difficult to get the face-piece to fit accurately. It is as great a piece of folly to expect a full-sized face-piece to fit a child as to put a child's foot into a boot made for a man six feet three.

Another source of annoyance is the presence of hard, bristly beard and whiskers which permit the air to be sucked in under the inflated margin of the face-piece. One must never neglect to ascertain whether the face-piece fits the face accurately, and if the hair round the face threatens to cause a leakage, the best plan is to rub some soap in and mat it together. Should a leakage still continue the remedy is to squeeze the bag or bags as the case may be, and to force the gas into the lungs under positive pressure. By such a procedure a small quantity of gas is forced outwards under the margin of the face-piece and prevents air from being drawn in.

The duty of the anæsthetist is to administer the anæsthetic, but his work does not terminate when he has done that. It falls to his lot to help the dental surgeon by holding the head firmly while the teeth are being extracted, and also to rapidly sweep a sponge round the mouth so that the blood may neither obscure the field of operation nor enter the stomach in any quantity. And even when doing this he must watch the general condition of the patient, and immediately on there being signs of "coming to" he must warn the operator of the fact. To proceed with the operation after such a warning has been given is a very unwise act, for the patient feels the pain and forms the idea that the anæsthetic is ineffective.

As, for the first time, we watch a patient pass under the influence of nitrous oxide we are apt to associate the condition induced with that of asphyxia, of which we have heard from the physiologist. We naturally ask ourselves whether the two states are identical. At first sight they appear to be so, but when we go more deeply into the subject we arrive at the conclusion that nitrous oxide has a true specific action producing unconsciousness in a way totally different from carbonic acid gas, or any other such asphyxiating vapour.

M. Paul Bert performed some interesting experiments by giving gas and oxygen under increased atmospheric pressure. The details are too long to give at the present time, but they support conclusively the statement that nitrous oxide has special anæsthetic properties quite apart from its asphyxiating action.

After all has been said about the mode of action, we are not of much use as anæsthetists unless we are familiar with the clinical aspects of the case. So let us watch an imaginary patient. During the inhalation of the gas we are able to note two steps in the physiological phenomena: (*a*) a pre-narcotic stage, characterised by mental and physical excitement; (*b*) a narcotic stage which becomes more and more profound as the administration is continued.

During the first few breaths the face becomes somewhat pale; a feeling of throbbing and fulness in the head ensues combined with tinnitus. There may be at this time exaggerations and perversions of the special sense; while other patients of a less neurotic temperament frequently experience pleasant dreams. As we watch the face we notice it acquires an ashy hue which becomes increasingly livid; the lips and other mucous membranes become almost blue-black; the breathing is more rapid and the pulse quickened and hard. The globes of the eyes are fixed; the conjunctivæ much reduced in sensibility and the lid separated. The inexperienced observer may be somewhat alarmed at the general condition of the patient, but there is no need for anxiety. The most reliable signs of satisfactory anæsthesia are: the snoring character of the breathing, the spasmodic contraction of the extensor muscles of the thumb, the oscillation of the eye-balls and the twitching of the eyelids. Should it be necessary to prolong the period of unconsciousness beyond thirty seconds one may safely give half-a-dozen more inhalations after the above mentioned signs have appeared; but directly respiration becomes of a stertorous character, the convulsive movements spreading to the arms and legs and the pupils dilating, it is time to discontinue the administration and allow the surgeon to do his work.

It may be asked whether one can lay down any rule as to what quantity of gas should be given. The reply is that no two cases are exactly alike, either in the amount necessary or in the duration of unconsciousness produced by a definite volume. The average time required for the production of narcosis is about seventy

seconds, and the quantity given in that period varies between three and four gallons. Thirty-five seconds may be taken as the average period of anæsthesia but these figures cannot be relied upon for practical purposes, for each case must be judged on the basis of the signs which appear during the administration.

The advantage to be gained by using nitrous oxide mixed with small quantities of pure oxygen, lies in the fact that, if the period of inhalation can be prolonged, the resulting unconsciousness is also longer. For example, we give nitrous oxide to a patient, but at the end of seventy seconds it becomes necessary to cease on account of threatening asphyxia. Let us in the same case use from four to eight per cent. of oxygen mixed with the nitrous oxide and we can continue the administration for one hundred and ten seconds, and even then there will be no threatening asphyxia. The face will be a good colour, the respirations quiet and the whole aspect of the patient peaceful; but, better still, there are no signs of returning consciousness for nearly double the time of the anæsthesia produced by pure nitrous oxide.

But I find my time is gone, and I am consequently precluded from bringing before you many other points that might have been of interest. Such as the amount of oxygen to be used in individual cases; the use of air mixed with gas, and of ether following nitrous oxide. Again, the subject of local anæsthetics and obtundants might have engaged our attention profitably. But as this paper has been an attempt to provoke discussion rather than to be exhaustive, I trust that it will in some measure have fulfilled its purpose.

If you will permit, now that this paper is finished, I will hand round the various appliances which are here for your inspection.

The President thanked Mr. Milligan for his excellent paper, and the meeting emphasized his thanks with considerable applause. A long discussion then took place. Amongst other things mentioned by the president was a piece of interesting information concerning Sir William Gull, who used to correct the ladies who complained that they had *weak* hearts by telling them that they had *tired* hearts. Some others taking part in the discussion were Messrs. Clayton, Dowsett, Mills, Prall and Dr. Lidiard. It was generally agreed by those speaking that chloroform, as an anæsthetic, had no place in dental surgery, and the secretary recorded a case at which he was present where artificial respiration had to be resorted to, chloroform being the anæsthetic; also that the College of Surgeons were responsible for a great amount of ignorance that existed amongst practitioners on the subject of anæsthetics by not altering the examination regulations, at the same time they were glad that most schools now offered facilities for learning anæsthetics if the student desired.

Mr. CLAYTON spoke of the gasometer and wondered that Mr. Milligan had omitted to mention such a useful appliance.

Amongst the instruments shown, Marston's Terminals attracted greatest attention, and Mr. MILLS suggested that if only the terminal could be in the form of a gag, the invention might be a very valuable one, but at present it rather interfered with the operator.

Further discussion was unfortunately curtailed by time, and Mr. MILLIGAN having replied, the Casual Communications were called for.

Mr. CLAYTON showed some upper molar forceps, which he had had made in accordance with his own idea. They differed from the ordinary pattern by having a forked palatine blade and a step on the handle to receive pressure from the thumb, thus relieving the palm of the hand to a certain extent, and at the same time increasing the facilities for driving the blades up when operating; Mr. Clayton's idea appeared to be well received, and it was suggested that he should indulge in a patent.

The SECRETARY showed three teeth, one illustrating erosion, combined with a stomatitic condition of the crown; a second showing the deposit of secondary dentine in the pulp; and a third showing exostosis and absorption.

The PRESIDENT then exhibited an exceedingly interesting specimen—an old clock-work dental engine, called "Harrington's Patent," and manufactured by Messrs. Smale in the pioneer days of dental engines (the date was unknown); straight and right angle attachments were with it, and a formidable key to wind up the machinery, also some burrs. The whole thing was made to hold in the hand after the style of an electric mallet. The disadvantages of this terrible antiquity were the frequency of rewinding, the large amount of friction and noise, and withal a very bad power, the burrs revolving but slowly at the best. On seeing and hearing this wonderful piece of mechanism work, it was easy to understand how a certain amount of dread of dentists has arisen amongst the public. This most interesting and perfect specimen having been inspected proceedings terminated.

Reviews.

Manual of Gynæcological Practice for Students and Practitioners. By Dr. A. Dührssen. Second English Edition, translated and edited from the Sixth German Edition, by John W. Taylor, F.R.C.S., Professor of Gynæcology at Mason's College, Birmingham, and Frederick Edge, M.D., Lond., F.R.C.S., Surgeon to the Wolverhampton Hospital for Women. (London, H. K. Lewis. Price 6s.)

The mere fact that this work has passed through six German and two English editions should be sufficient guarantee of its importance as a standard book on practical gynæcology, and the written experience of Dr. Dührssen will undoubtedly be read with great interest by every medical practitioner.

The book has been thoroughly revised, extended and brought up to date. Many recent operative procedures are described, including Snegireff's method of zesto causis. This treatment has been recommended for uterine hæmorrhage, especially at the climacteric. It consists in scalding the endometrium with steam at the temperature of 100° C., the steam being carried in to the previously dilated uterus. The author seems satisfied with the efficacy of this method, although he lays special stress on the necessary precautions, the neglect of which has met with such disastrous results on the Continent.

The translators have increased the value of the book by their introductory chapters on the anatomy of the female genital organs, and they are to be congratulated for bringing before our notice many points which are usually neglected in English text-books.

The text is illustrated by 125 diagrams which elucidate and simplify the descriptions of many of the instruments and operations.

We compliment Mr. Lewis on producing such a high class work for the small sum of six shillings.

Tuberculosis: Its Nature, Prevention, and Treatment, with Special Reference to the Open Air Treatment of Phthisis. By Alfred Hillier, M.D. (London, Cassell & Co. Price 7s. 6d.)

This is the first book in English which has dealt with the subject of tuberculosis from every point of view, and it should be welcomed as a valuable work of reference by all practitioners and students of medicine.

Dr. Hillier's book is interesting from a social as well as a medical point of view. The prevention of tuberculosis concerns the legislator as well as the doctor, and the author hopes that his chapters on prevention by legislation and public action will be read by members of local authorities who now control sanitation and public hygiene. The extensive use of the tuberculosis test in cattle is strongly advocated, and Dr. Hillier trusts that this test will not be neglected by agriculturists.

In an appendix we find two leaflets on "How to Prevent Consumption," and "Fresh Air and Ventilation," and also the recommendations of the second Royal Commission on Tuberculosis.

The print, paper and binding are all that can be desired, while the text is illustrated by 31 illustrations and three coloured plates.

Practical Manual of Diseases of Women and Uterine Therapeutics for Students and Practitioners. By H. Macnaughton-Jones, M.D., President of the British Gynæological Society. Eighth edition, revised and enlarged with 640 illustrations and 28 plates. (London, Ballière, Tindall & Cox. Price 18s. net.)

The author, in this edition, has presented his work in an entirely new form. This has been found necessary owing to the many advances in our knowledge of the etiology and pathology of the diseases of the female generative organs, to our improved methods of investigating them, as well as to increased facilities for operative treatment.

The first fifty pages of the book are devoted to a summary of anatomical and clinical facts which have a bearing on gynæcological practice. The second chapter deals with the various methods of making a careful and systematic examination of the patient. This is a chapter full of good and sound advice. Dr. Macnaughton-Jones deprecates unnecessary examination of the uterus, but, on the other hand, maintains that "nothing can be more dangerous to a medical man's reputation than the neglect of making a careful vaginal examination when he has doubt as regards the nature of a difficult case, with symptoms pointing to some affection of the pelvic viscera. Want of caution in this respect has brought many a young medical man into disgrace." Special attention is drawn to the importance of considering carefully the history of the case, and all the appliances necessary for diagnosis are described in detail, and their uses are more clearly brought before our notice by the numerous diagrams and photographs which are found on every page.

The chapter on asepsis and antisepsis could be read with profit by other than gynæcological surgeons. In most emphatic tones he lays down that there can be no possible excuse for even the slightest defect in any of the details of aseptic surgery, and that any accident due of a flaw in the method is simply unpardonable. Quoting Doyen, he says that the commonest cause of death after operative measures have been taken is infection in the operative tract, and he cannot too strongly insist upon the point that "many surgeons commit the grave error of believing themselves *à priori* aseptic, and account for their failures by causes other than the direct infection from the wound."

Dr. Macnaughton-Jones has included a description of the diseases of the adjacent structures and organs to the generative tract, including those of the urethra, bladder, ureter, kidney and rectum. This is most useful from a diagnostic point of view, as one meets with many cases where the symptoms are so vague that any of these organs might be the source of the trouble.

The value of the work as a clinical manual is greatly increased by the fact that the author has given us the benefit of his own large experience, and the description of the various diseases is made more real to the young practitioner and student by the inclusion of notes on cases met with in his own practice and those of other well known gynæcologists.

We have no hesitation in pronouncing this to be the best text-book on gynæcology which has been published for many years past.

Lateral Curvature of the Spine. By George Steele-Perkins, M.D. Being a paper delivered before the South-Eastern Branch of the British Medical Association, November, 1899.

Sport.

Cricket.

GUY'S 2ND XI. v. CROYDON 2ND XI.

(DRAWN.)

Played at Honor Oak Park, on Saturday, May 12th.

Our opponents turned up late, and batting first occupied the wickets the greater part of the afternoon Guy's, left with three quarters of an hour's batting, scored 56 runs for the loss of three wickets. Collins played a good not out innings of 20. Scores:—

CROYDON.

C. P. Wicks, b Morres	0
G. F. Long, c Barber, b Carlisle	5
G. H. Smethurst, b Carlisle	6
M. W. Robinson, b Hicks	17
C. H. Richer, b Carlisle	15
V. G. Butler, c Strange, b Chignell	12
C. Woolcott, not out	53
A. E. Drage, b Chignell	4
R. Archer, b Chignell	4
C. Watson, b Carlisle	29
A. S. Bush, b Strange	3
Extras	24
Total	172

GUY'S

H. Barber, b Drage	14
F. Morres, c Bush, b Butler	0
E. A. Collins, not out	20
Tollhurst, b Butler	0
A. H. Turner, not out	10
Extras	12
Total	56

H. T. Palmer, W. H. Bush, E. W. Strange, J. T. Hicks G. Carlisle, J. A. Chignell, did not bat.

Guy's Hospital Lawn Tennis Club.

GUY'S v. SOUTH CROYDON.

The first match of the season, played May 12th at South Croydon, resulted in a very level game. The result was against us, 5 matches to 4, 10 sets to 9, or 89—84 games. Considering it was the first match the result was very creditable. Although they played together for the first time, Lacey and Bacon got on well, and were the only ones to get a set off our opponent's first couple. Wedd and Jupp played a very strong game. Day was scarcely up to his usual form.

SCORE.—H. K. Lacey and H. Bacon lost to Jephson and Bull, 2–6, 6–3, 0–6; beat Whaite and Williams, 6–1, 6–2; beat Kent and Hoddett, 6–1, 6–4. E. N. Jupp and B. H. Wedd beat Whaite and Williams, 6–2, 6–8, 6–1, lost to Jephson and Bell, 2–6, 5–7; beat Kent and Hoddett, 6–1, 6–4. L. Cooke and W. L. M. Day lost to Kent and Hoddett, 2–6, 3–6; lost to Whaite and Williams, 5–7, 1–6; lost to Jephson and Bell, 1–6, 3–6.

Guy's Hospital Athletic Club.

The Annual General Meeting of the above Club was held on May 18th. Mr. Clement Lucas in the chair. The following officers were elected. President: R. Clement Lucas, Esq., B.S. Hon. Secs.: R. S. Roper, D. H. Trail. Committee: E. M. Harrison, S. P. Wadson, H. B. German, H. M. Langdale, R. C. Mullins, R. E. Brayne, A. C. H. Gray, L. G. Nash, H. V. Bagshawe, M. D. Wood, C. T. Hilton.

The Sports have been fixed for Thursday, June 21st, at Honor Oak Park.

R. S. ROPER,
D. H. TRAIL, } Hon. Secs.

Pass List.

Royal College of Surgeons of England, May, 1900.

FINAL EXAMINATION FOR THE L.D.S. ENG.

R. W. Allen, J. Bennett, E. Couchman, A. C. Edwards' P. H. Furnivall, A. M. Gabriel, J. H. Greenwood, W. Jarvis, L. C. A. Knight, A. L. Lambert, R. C. G. May, C. S. Morris, K. C. Ness, S. L. Prall, R. B. Recordon, W. R. Searle, H. L. Shelton, A. M. A. Stevens, J. L. Wartski.

NEW REGULATIONS.

FIRST PROFESSIONAL EXAMINATION.

MECHANICAL DENTISTRY AND DENTAL METALLURGY.—S. Clifford, F. G. Day, E. J. Gaffney, R. J. Green, W. H. Peatfield, J. F. Rey.

MECHANICAL DENTISTRY ONLY.—C. D. Wood.

DENTAL METALLURGY ONLY.—J. B. Barron.

University of Durham, April, 1900.

DOCTOR IN MEDICINE.

J. Harris.

DIPLOMA IN PUBLIC HEALTH.

A. J. Collis.

THIRD EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE.

H. C. Sturdy (obtained Second Class Honours), S. C. Clapham, A. Reid.

Births.

HICKMAN.—On April 28th, at Overton House, Wanstead, Essex, the wife of Herbert V. Hickman, M.B. Lond., M.R.C.S., L.R.C.P. Lond., of a son.

PEARSE.—On May 10th, at 110, Cathedral Road, Cardiff, the wife of Athol S. J. Pearse, M.A., M.B. Camb., M.R.C.S., L.R.C.P. Lond., of a daughter.

ED.—S. H.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well a subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

June, 1900.

Sat. 9.—Messrs. Lucas and Lane's take-in; Drs., H. S. French and H. K. Lacey; Cl., E. W. Goble.
G.H.C.C., I., Waldegrave Park, home.
II., Croydon, away.
G.H.L.T.C., I., Redhill, away.
II., Gipsy, home.
Hos.-Scho. C.C., Park, away.

Mon. 11.—Cambridge 1st and 2nd M.B. Exam. begins.
1.15 p.m. Clinical lecture by Mr. Brailey.

Tues. 12.—Schedules for Final Conjoint Exam. to be left at the Medical School Office not later than this date.
12 noon. Mr. Rowell's Demonstration on Anæsthetics.
G.H.S.C., St. Saviour's S.C., Southwark Baths.

Wed. 13. G.H.C.C., I., Hornsey, away.
1.30 p.m. Clinical lecture by Dr. Hale White.

Thur. 14.—Messrs. Golding-Bird and Dunn's take-in; Drs., R. Thompson and L. Hirsch; Cl., H. McD. Parrott.
G.H.C.U. Missionary Meeting. Address by J. Lamperd, Esq.

Fri. 15.—1.15 p.m. Clinical lecture by Mr. Dunn.

Sat. 16.—G.H.C.C., Past *v.* Present, home.
G.H.L.T.C., Past *v.* Present, home.
Hos.-Sch. C.C., St. George's, away.

Mon. 18—1.15 p.m. Clinical lecture by Mr. Symonds.

Tues. 19.—12 noon. Mr. Rowell's Demonstration on Anæsthetics.
G.H.S.C., Barry S.C., Southwark Baths

Wed. 20.—1.30 p.m. Clinical lecture by Dr. Hale White.
G.H.C.C., II., City of London School, home.
G.H.L.T.C., I., Staff, home.
II., Gipsy, away.

Thur. 21.—Messrs. Jacobson and Fripp's take-in: Drs., H. C. Keates and A. Wylie; Cl., C. B. Thomson.
G.H.A.C., Annual Athletic Sports, Honor Oak Park.
G.H.C.U., Students' Meeting.

Fri. 22.—1.15 p.m. Clinical lecture by Mr. Dunn.

Sat. 23.—G.H.C.C., I., Eastbourne, away.
II., Old Charlton, home.
G.H.L.T.C., I., Wanstead, away.
II., St. Thomas's, home.

Guy's Hospital Gazette,

JUNE 9, 1900.

Insular Sclerosis

CLINICAL LECTURE BY DR. NEWTON PITT.

November 11th, 1899.

(Continued.)

GENTLEMEN,—In continuation of my lecture last week on Insular Sclerosis, I propose to-day to go more fully into (1) the plantar reflex under different conditions, (2) the differentiation of insular sclerosis from the various diseases with which it has been confounded, and (3) its pathology.

The plantar reflex.—Babinsky last year drew attention to the fact that in cases in which there was any lateral sclerosis, the plantar reflex differed from the reflex which occurred normally, in the fact that on tickling the sole of the foot, the toes, instead of being flexed, are extended.

Van Gehuchten also confirmed his observations. Since then we have noted this symptom in many cases in the wards. A most complete investigation, however, has been carried out by Dr. Collier, who has systematically examined, at the National Hospital, Queen's Square, a very large number of patients with every variety of nervous disease; also, a number of children at Great Ormond Street, and likewise a number of adults with non-nervous lesions. I propose

to put before you to-day, the conclusions at which he has arrived.

The best position for the limb in order to obtain the reflex, is with both hip and knee flexed and the leg rotated out, so that the patient lies with his knee slightly raised on a pillow. In the normal reflex tickling under the big toe will give the best reflex, whereas in the abnormal reflex you may do better by tickling the outer part of the sole.

To describe, first of all, the normal reflex: The other superficial reflexes may frequently be absent, even in health, but the plantar reflex is almost always present, and normally is one of flexion of the toes. The conditions, independent of disease, in which it may be absent, and even then only temporarily, are, when the feet are cold or are perspiring very freely, but when you dry the feet and improve the circulation by warmth or friction you can almost always in health elicit the reflex. There is no doubt, however, that in many hysterical patients—and this sign is therefore of especial value in functional paraplegia—the reflex is absent comparatively often. When you tickle the sole of the foot it will depend partly on the individual and partly on the stimulus as to what amount of reflex occurs. The afferent path of the reflex is by the fifth lumbar and the first sacral nerves. A very slight scratch will often give a better reflex than a more vigorous one.

The first muscle to contract is the tensor vaginæ femoris. Put your hand over the hip and you will notice that even with a minimum stimulus the tensor vaginæ will contract before any of the muscles in the leg or foot. In the normal condition the first muscle therefore to contract, and sometimes the only one, is the tensor vaginæ femoris; the contraction is a quick one. This is succeeded by flexion of the toes, the smallest toes perhaps flexing more than the others. As the toes flex they are drawn together and adducted, and if you increase the stimulus you find that not only are the toes drawn together, but that the foot tends to be inverted and dorsiflexed. When the stimulus is sufficient to affect more muscles, the tendency is for the whole leg to be drawn up, both knee and hip flexed and the leg carried across to the other side by adduction and internal rotation of the thigh. The complete reflex is therefore, in order, a contraction of the tensor vaginæ femoris, a flexion of the toes, a drawing together of the toes, a dorsiflexion of the ankle, an inversion of the foot, a flexion of the knee and hip, with adduction and internal rotation of the thigh, but only the first or a few of the movements may take place. The most important feature is the flexion of the toes on the metatarsal bones. In observing the reflex the mistake you are likely to make is to assume that the upward movement of the ankle, which is not the essential part of the reflex is an extensor reflex, confounding it with the upward movement of the toes at the metatarso-phalyngeal joints.

You cannot elicit the normal reflex with the certainty that you can obtain the extensor reflex which is present when there is a lesion in the lateral columns. If you examine the feet of babies one or two years old who have not yet walked, you will notice that instead of a flexor, they have an extensor reflex, but after a child has learned to walk the flexor reflex develops. Until a child can walk, when you tickle the sole of the foot the great toe is raised, the toes are separated and the foot is everted, the movements of the hip and extensor vagina femoris develop after these other movements. The movement is a quick one, and the extensors of the toes are the first to act. It is not always elicitable. The toes become extended and separate, more particularly the great toe. I do not know that it makes very much difference what part of the foot you tickle. The movement of the ankle is dorsiflexion, with eversion differing from the inversion which occurs in people who walk.

When you examine patients who have any lesion of the lateral column, the reflex is different; this alteration is particularly valuable because it may be the first evidence there is of any change in the lateral columns. The only condition so far as we know at present in which you will fail to obtain an extensor reflex with a lesion in the lateral columns, is with a complete transverse lesion of the spinal cord. With an *extensor reflex* the toes, and especially the great toe, are extended and spread apart, but the movement is more deliberate than in the normal flexor reflex, while it is more deliberate it is also much more constant. You can always elicit it. The tensor vaginæ femoris contracts later than the extensors of the toes. There is much less movement of the ankle; there is not the vigorous raising of the ankle which takes place normally, and the outer side of the sole is the best place to stimulate.

An examination of a large number of patients in the hospital at Queen's Square, showed that this was a very valuable sign of a lesion in the lateral column, because it was found to be almost invariably present with insular sclerosis, hemiplegia, myelitis, Friedreich's disease, combined sclerosis, and whenever the lateral columns were

sclerosed. Taking thirty cases of insular sclerosis under treatment during the year, twenty-eight gave the extensor reflex, giving in this disease the earliest indication that the lateral columns are involved. In five cases which had been under observation, diagnosed as functional paraplegia, the extensor reflex was found, and largely in consequence of this, the diagnosis was altered to insular sclerosis, and further development proved that this was correct.

The extensor type of plantar reflex was also present in a series of cases of spastic paraplegia; in twenty-eight out of thirty-six cases of hemiplegia it was found on the paralysed side; also in Friedreich's disease, in syringomyelia, and in some cases of progressive muscular atrophy, in which, as you know, there is usually also some change in the lateral columns. It was also most interesting to find that besides these definite organic diseases, the extensor reflex occurred in cases of strychnine poisoning, in tetanus, and immediately after epileptic attacks. In all these there will probably be discharges down the lateral columns, so that they become exhausted, and hence the extensor reflex takes place. Although these observations with regard to the variations in the plantar reflex are comparatively new, it shows that we have a physical sign which is really of very great value, and, as it occurs with the earliest changes in the lateral columns, it will often put you on your guard and enable you to make a correct diagnosis.

DIAGNOSIS.

A. TREMORS.

Difficulties may arise in distinguishing the *tremor* from that which occurs in other diseases, and in insular sclerosis the tremors have a moderate rate; they vary from five and a half to seven and a half per second. In paralysis agitans the tremors are slower. If you watch a patient with insular sclerosis you fancy the tremors are quick, but this is partly due to the fact that the amplitude of the movements is much greater than that which occurs in other forms of tremor, and you can understand that if the amplitude of the movement of the limb is large, it gives the idea of a quick tremor, yet the rate of vibration may be comparatively slow. Although the tremor appears to the eye to be rapid, it is not really so. When a patient with insular sclerosis tries to touch a particular object, the oscillations tend, as the effort continues, to increase in amplitude. The typical tracing of a tremor in insular sclerosis is small at the commencement, with a rapid increase in the amplitude of the movements. The rate of increase is fairly constant.

The tremor due to *mercurial poisoning* may offer some difficulty. A patient with mercurial tremor can control it for a time, when it will begin again; there is not the steadily increasing amplitude and constant oscillation which is present when a patient with insular sclerosis attempts to touch an object.

The tremors of *paralysis agitans* differ, in the fact that they go on continuously, whether the muscle is at rest or not. In insular sclerosis the tremors cease when the patient is lying in bed, and they only come on when he is making any movement, although in both insular sclerosis and paralysis agitans movement increases the tremor. The tremors in paralysis agitans therefore are rather slower, of much smaller but of fairly constant amplitude.

In *chorea* the movements are erratic, and if you are familiar with the two diseases you are not likely to make a mistake. Twenty years ago, when these diseases had not been studied so carefully, many were called chorea, but now this mistake is not likely to occur. In *Friedreich's disease* the tremor does not steadily increase in amplitude, and the other physical signs, such as the loss of knee-jerk, the affection of speech, and the marked spinal curvature, quite suffice to distinguish the disease; the plantar reflex is of the extensor type, because there is sclerosis in the lateral columns.

B. HYSTERIA.

In an early stage the great difficulty is to diagnose the disease from *hysteria*. This is by far the most common mistake, so I would draw your attention to the following points of distinction. The tremor ought not to lead to a mistake, because in hysterical patients the tremors, although they are rhythmical, do not increase on an attempt to perform any movement, and in many there are no tremors at all; when present they are rhythmical and more uniform and often of considerable amplitude. The following signs, however, are especially characteristic of insular sclerosis:—

1. *Nystagmus*.—In many patients it is only present, when they look laterally, but not when the eyes are at rest. In the exceptional cases of hysteria in which nystagmus is present, it is always associated with rapid blinking of the eyelids, but these cases are very rare. I have seen two patients with constant nystagmus associated with rapid blinking of the eyelids.

2.—*Ankle clonus* and (3) the *extensor plantar reflex* are often present in insular sclerosis, but neither of them are present in hysteria.

4.—The presence of, or the history at some time or other of, an *ocular paralysis* and of a defect in the field of vision. In hysteria the field of vision is often limited as in insular sclerosis, but on investigation you will find in the latter that in the area lying outside the field for red and inside that for form, the patient will appreciate a red spot merely as black and a green one as white—a condition which does not occur in hysteria.

5.—*Optic atrophy*, more or less complete, is commonly present, but it is not in hysteria. But I would add that insular sclerosis is one of the organic diseases to which functional symptoms are very often superadded, and although you may convince yourself that certain symptoms are functional, you do not thereby exclude the possibility of there being also organic disease.

C. Scanning Speech.

This defect of speech often raises the difficulty as to whether the case may be one of *general paralysis of the insane*. It is somewhat difficult to describe the difference, but when you have met a few cases of each you will find they are very characteristic; the difficulty mainly consists in attempting to get a clear idea of the peculiarities of the speech from a description in a book. I should say that the main points are these: that the patient with insular sclerosis is very deliberate, and the word *scanning* is not at all inappropriate in describing his speech. His pronunciation of syllables is both deliberate and monotonous. The language of a general paralytic is very slovenly, he cuts short syllables and mispronounces words. A patient with insular sclerosis rarely mispronounces except as far as accent is concerned, and is defective in pronouncing certain sounds. In general paralysis the language is much less correct and fluent, and much more spasmodic and slovenly. Still, I quite grant, that until you have seen a few cases of both, it is difficult to obtain a perfectly clear idea of the distinction; but when you have once heard a typical patient with insular sclerosis talk, you can never mistake the speech again; there is something in the monotonous drawl which is very striking.

Occasionally when you meet with a slow speech and nystagmus, the question of *cerebral tumour* will be raised, but there will also be headache, vomiting, and optic neuritis.

D. *Acute myelitis*.—The patient in Mary ward last year came in with acute paraplegia. This may be the main symptom which insular sclerosis presents, and the only way to distinguish it from myelitis is by looking out for other signs, as nystagmus, optic atrophy, limitation of the field of vision, and a history of a previous paralysis which has cleared up. In this case we overlooked or did not pay sufficient attention to the very definite history of a paralysis that had completely cleared up, and which would not have been at all probable had the lesion been an acute myelitis.

E. It is difficult to distinguish *ataxic paraplegia* from an early stage of insular sclerosis, because the tendency in insular sclerosis is, first of all, to a spastic, and later, to an unsteady gait, which both are also present in the other disease, but optic atrophy is exceptional in ataxic paraplegia, nor do nystagmus and speech-defect occur. In an early stage of insular sclerosis, however, there is a period when you cannot be absolutely certain of your diagnosis.

F. *Tabes*.—The difficulty particularly occurs in connection with the explanation of optic atrophy. In insular sclerosis the atrophy is often confined to part of the disc and is less complete than in tabes. There is also more or less central scotoma, and the vision tends to vary, from time to time, much more. By paying attention to the condition of the knee-jerks, the absence of pain and other marked sensory disturbance, such as occur in tabes, you ought to be able to make a diagnosis.

There is another feature which is often well-marked in this disease to which but little attention has been drawn in England, viz., the emotional condition of these patients, and their tendency to irrepressible laughter. Although I have seen a considerable number of patients with irrepressible laughter, as, for instance, with hydrocephalus, hemiplegia, cerebral tumour, or insular sclerosis, I must confess it never has occurred to me to try and associate this symptom with any definite local lesion. But Professor Brissaud has collected a series of cases together, and has come to the conclusion that all these cases of irrepressible laughter and tears, are associated with a lesion in the anterior part of the optic thalamus, which has also damaged the fibres in the anterior portion of the internal capsule. Patches of sclerosis in this disease are frequently met with in the great nuclei at the base of the brain, and it is very possible that the abnormal emotional condition of these patients, and the ridiculous way in which they burst out into laughter upon the slightest cause, may be associated with some definite localized lesion.

Pathology.

We now pass on to the pathology of insular sclerosis. The appearances of the patches

of disease in the spinal cord at the post-mortem, at once attract attention, and in colour, etc., differ from those found in other nerve lesions. Scattered through the whole of the nervous system—brain, spinal cord, and nerves—according to the stage of the disease, are patches more or less numerous, and varying in size from a millimetre up to two centimetres, of gelatinous-looking material, somewhat reddish-grey in colour and varying in consistency. In the acute patches, it is soft; in the chronic, it is firmer than the rest of the nervous tissue. The material also varies in its vascularity. It is sometimes level with the rest of a section, but it is not at all infrequent for it to lie below the surface; and in acute patches it may even project above. There is no fixed rule; it depends entirely on the duration of the patch—whether it is an early or a late stage—as to whether it tends to swell up or to shrink.

Patches certainly occur more frequently in some areas that in others. On the whole, the floor of the fourth ventricle, the pons, the walls of the lateral ventricles, the white matter of the brain and spinal cord, are the areas most commonly affected; and not infrequently the optic thalamus and candate nucleus at the base of the brain. The cerebellum is less often invaded, and the cortex much less than the white matter. In the cord also the grey matter is less frequently affected than the white tissue. Still there is no portion of the nervous system which may not be affected.

It is only recently that the nerves have been systematically examined, but now that this is done with care it is found that many patches can be discovered. Almost all the cranial, and also the peripheral nerves, have shown patches of diseases in different cases. The affected areas in the cord are much more obvious when the specimens have been hardened in bichromate of potash. An affected patch generally contains blood vessels in the centre, and the most dense glia tissue is round the blood-vessels. If you examine a patch under a microscope, you will notice the white sheaths of Schwann have entirely disappeared, while the axis cylinders persist, and there is a large increase in the neuroglia tissue, but you have normal sheaths round the nerves immediately adjacent to these spaces. If you make a longitudinal section of the spinal cord a patch of sclerosis is generally longer than its transverse section, and the line of demarcation at the ends is not nearly so sharp as it is at the margin of the transverse section.

To describe more minutely the appearance of the patch: It varies much according as the patch is old or new, but in the centre of an old patch there is much connective tissue and many glia cells, with very often large spider cells, which are less marked at the periphery. There is a tendency for the neuroglia fibres to run longitudinally in the spinal cord, whereas if you examine a patch of sclerosis in the grey matter you simply have an irregular felt work of fibres. But the most remarkable feature of the change is, that very rarely do the axis cylinders disappear; still occasionally in very chronic cases they have disappeared from the centres of sclerotic patches, but more often they persist for years after the sheaths have disappeared, and are almost always present. The cells in the cortex and in the grey matter of the cord tend to persist unchanged. Occasionally, in very old patches, there are pigmentary changes, with degeneration in the cells; but these are possibly secondary. The evidence points to the changes in the nervous element being secondary to those in the neuroglia.

It is noteworthy that in a section of the cord above or below one of these sclerotic areas, no secondary degenerative changes develop. In almost all other lesions affecting the white columns, the axis cylinders become more or less damaged and a Wallerian degeneration ensues in the columns above or below. The sclerotic patches are sharply defined transversely, they consist of axis cylinders, with a neuroglia which contains fewer cells and is more fibroid and sometimes structureless in the centre than at the periphery; there is no doubt that as the disease progresses the patches increase both in number and in size.

The walls of the blood vessels in the centre of the sclerotic patches thicken, the perivascular sheaths are often distended with cells when the patch is acute, but where the patch is chronic, the wall is thickened and the perivascular sheaths no longer contain cells, but occasionally you will find that thrombosis has occurred in the vessels.

Now, how are we to explain these changes? I have pointed out that as a rule secondary changes do not occur either above or below one of these areas, but in some cases you may find a slight degenerative change for a short distance, still occasionally cases have been described in which there has been a secondary degenerative change. We should be inclined to say that while degenerative changes are very rare even in chronic cases, they will occasionally take

place, and that their development probably varies with the intensity of the primary process.

Four theories have been put forward to explain the development of these areas of disease. First, that it is an interstitial change commencing in the neuroglia, and only involving the essential nerve elements secondarily. The next theory is that it is essentially a parenchymatous lesion starting in the nerve elements themselves. The third theory, which is put forward by Marie, in Paris, is, that the disease is essentially a vascular one, that it starts from a poison circulating in the vessels, the toxin passing out and damaging the adjacent nerve tissue. A fourth theory is put forward by Nothnagel, viz., that the lesion is a new growth, that it is really a multiple disseminating gliosis throughout the nervous system in the same way that multiple fibromata, lipomata, or neuromata may develop elsewhere. Only the neuroglia being more stable, the changes take place slowly over as many years as it takes months in some of the other diseases.

To say a word or two in regard to these various theories. In discussing the etiology I pointed out that while various facts have been collected we are practically absolutely ignorant of the etiology. Undoubtedly, as Oppenheim and Marie have pointed out, in a certain number of cases, typhoid fever, small pox, influenza, plumbism, and other intoxications have preceded the development of the disease. But it is probably difficult, in France, or on the Continent generally, to find any nervous disease which has not sometimes been preceded by typhoid. Not so many years ago most patients with rare nervous diseases in Germany died of typhoid fever, because there was so much typhoid in the hospitals that a patient who was kept in for months ran a great risk of dying from typhoid. But this accident has nothing to do with the etiology of the disease.

The view that the disease is the result of various toxins seems to me unsatisfactory. One can quite understand a poison, such as that of diphtheria or typhoid, passing out of the vessels and producing an area of necrosis or abscess; but it is quite incomprehensible that having done so nothing further should happen for some years, and then suddenly other areas of disease should be developed in the nervous system. We have no evidence that these toxins are capable, after ten or twenty years, of suddenly becoming reinvigorated and bringing about changes in the nervous system. Therefore when you have this development of new areas, and an increase in the size of these areas, after many years, the known toxins seem hardly sufficient to explain the change; the only exception being a toxin such as syphilis which is capable of setting up degenerative changes years afterwards. But there is no evidence that the disease has any connection with syphilis.

Whether the sclerosis is primarily vascular, primarily parenchymatous, or primarily interstitial, none of the theories will explain the development of new areas after an interval of several years, with the exception of the theory of new growth.

What evidence is there in favour of the lesion being a new growth? Strumpell reports two cases in which the sclerosis was accompanied by syringo-myelia. This latter is a disease in which there is a tendency for the neuroglia around the central canal of the cord to form an overgrowth, and will ultimately lead to a distension of the cord itself. The overgrowth cannot be described as having any definite limit, but still as a rule it starts round the central canal. In two cases, then, this condition of syringo-myelia was associated with areas of disseminated sclerosis scattered throughout the nervous system, and he put forward the view that the changes were all due to a glioma.

On seeing Prof. Strumpell's paper I was reminded of a post-mortem in 1886, at which I obtained the spinal cord from a case with glioma in the left half of the pons and cerebellum. On cutting it up some months later, instead of finding simply descending sclerosis as I had expected, I came across areas of disseminated sclerosis. Clearly that is exactly a similar case of glioma in the pons with disseminated nodules scattered through the cord.

Mr. Wilkin has made an abstract of the report of this case for me. The man was forty-two years of age, and was admitted for what was supposed to be a cerebral tumour. He had defective vision, no scotoma for colours, but soon after admission he became blind. There was double optic neuritis, numbness on the left side of his face and in his left hand, speech thick, but no definite aphasia, nystagmus in the right eye with an internal strabismus. His left arm was weaker than the right. There was facial paralysis on the left side, he was unable to walk properly, his knee-jerks were present, the plantar reflex was well marked, there was no ankle clonus. The man became more and more drowsy and torpid, but nothing is definitely stated with regard to his gait except that he was unable to stand alone, and that there was general weakness. He became very noisy, had

great respiratory trouble, with Cheyne-Stoke's breathing, and finally died.

While the whole question is a difficult one, it seems to me that we can best explain the appearances by the view that there is a disseminated growth of neuroglia scattered throughout the nervous system. It is not quite clear why in syringo-myelia the growths should particularly pick out the grey matter and the central canal, while in insular sclerosis there is a tendency to avoid those regions. There are some obvious objections to this theory, but still there is a great deal to be said for it.

Explanation of the tremor. Is the tremor due to a lesion in any particular part of the nervous system? It was thought at one time that the tremor implied that there was a lesion in the optic thalamus or in a definite portion of the pons, but this is probably not the explanation. The tremor is probably due to the fact that in order to perform any particular movement, such as to shut your hand, you have not only to contract the flexors, but also to relax the extensors; and when a stimulus is sent from the brain to perform any movement accurately, you must send the two stimuli exactly at the same time, so that one muscle relaxes at the time the other contracts. Now, if you have small patches of sclerosis in which the axis cylinders lie bare, the probability is that the rate of transmission and energy of stimulus is altered, and that the stimulus which goes to one muscle, owing to the nerve being bare, is disturbed, and consequently the two stimuli will not come simultaneously. There is a stimulus first to one muscle and then to the other, each stimulus setting up a reflex action at a different time, and hence the tremor. So that the tremors result not from a lesion in some particular spot, but from interference with the nervous tracts, interference with the stimuli to the extensors more than with those to the flexors in certain cases, and *vice versâ*, and hence the two stimuli do not arrive at the same time.

Nursing News.

Matron's Office.

On June 2nd, Nurse M. C. Allen (Head Nurse in Naaman) left the hospital at the end of her three years' training, to take up private nursing work at the Institution. Probationer E. Creasey has been appointed to succeed her as Head Nurse in Naaman ward.

On June 4th, Nurse Overbury was transferred to Astley Cooper ward, and Probationer Rainbow was appointed Head Nurse in Lazarus ward in her place.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Taylor.

Mary	38.	Multiple serous effusions. ? Tubercular.
	39.	Phthisis. Tubercular laryngitis.
	41.	Myelitis. Paraplegia.
	44.	Malignant growth in liver. ? Primary in gall-bladder.
	46.	Carcinoma of stomach. Secondary deposits in liver.
	49.	Epithelioma of œsophagus. Gastrostomy.
	50.	Hemiplegia. Hemianæsthesia.
Philip	23.	Pleuritic effusion. Jaundice.
	27.	Phthisis. ? Tubercular peritonitis.
	28.	Phthisis. Pneumo-thorax.
	30.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
	31.	Locomotor ataxy. Primary optic atrophy.
	33.	Mitral stenosis and regurgitation. Tricuspid regurgitation. Pulsating liver.
	34.	Phthisis. Æt. 72.
	35.	Pernicious anæmia.

Cases under Dr. Hale White.

Mary	14.	Chorea.
	15.	Exophthalmic goitre.
	19.	Gastric ulcer.
	20.	Hemiplegia.
	22.	Mitral stenosis and regurgitation.
	23.	Pleurisy with effusion.
	24.	Movable kidney.
Philip	2.	Mitral stenosis and regurgitation.
	3.	Left hemiplegia.
	5.	Pericarditis.
	6.	Mediastinal growth. Left pleuritic effusion.
	7.	Thoracic aneurysm.
	9.	Carcinoma of stomach. Gastrostomy.
	12.	Phthisis.
	13.	Cirrhosis. Perihepatitis.
	14.	Meningitis.
	20.	Pleurisy with effusion.

Cases under Dr. Pitt.

Mary	25.	Acute nephritis.
	26.	Purpura.
	27.	Diabetes insipidus.
	28.	Thrombosis of iliac veins.
	30.	? Angina pectoris.
	32.	Hysteria.
	33.	? Renal calculus.

MARY	35.	Syphilitic thrombosis of brachial artery and gangrene of fingers.
	36.	Pleuritic effusion and ascites.
	Cot.	Marasmus.
STEPHEN	21.	Pleuritic effusion.
	22.	Pleurisy and degenerate cardiac muscle.
	23.	Infantile hemiplegia.
	24.	Empyema. Pneumococcal.
	25.	Lardaceous disease.
	26.	Acute rheumatism. Mitral incompetence.
	27.	Eczema.
	28.	Pleuritic effusion.
	29.	Pleuritic effusion.
	31.	Chorea.
	33.	Carcinoma of kidney.
	34.	Diabetes mellitus and phthisis.
	35.	Nephritis.
	37.	Malignant growth in lung.
	39.	? Carcinoma of stomach.
	Cot.	Infantile hemiplegia.

CASES UNDER DR. PERRY.

MARY	1.	Hydrocephalus.
	3.	Aortic and mitral disease.
	7.	Lobar pneumonia. Enteric.
	10.	Ascites. Aortic and mitral incompetence.
	12.	Pontine hæmorrhage.
STEPHEN	1.	Pneumothorax.
	5.	Ascites. Cirrhosis.
	6.	Lobar Pneumonia. Pericarditis. Empyema.
	9.	Malignant growth of œsophagus.
	12.	Acute rheumatism.
	13.	Mitral stenosis and regurgitation.
	15.	Lobar pneumonia. ? Meningitis.
	17.	Carcinoma of stomach. Secondary deposits in skin.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

ASTLEY-COOPER	1.	Fractured ribs and pelvis.
	7.	Supracondylar fracture of femur.
	30.	Fractured patella.
JOB	3.	Periostitis of femur.
	7.	Gumma of tongue becoming epithelio-matous. Excision of tongue.
	11.	Epithelioma of upper lip.
LYDIA	7.	Compound comminuted fracture of elbow. Amputation.
	10.	Carcinoma recti. Colotomy.
	12.	Compound fracture of radius and ulna. Simple fracture of humerus.
	19.	Hæmorrhoids.

CASES UNDER MR. LUCAS.

ASTLEY-COOPER	3.	Ruptured urethra.
	25.	Lacerated foot. Amputation of toes.
MARTHA	17.	Dorsal caries. Kyphosis.
	21.	Sinus after nephrolithotomy.
LAZARUS	2.	Fistula in ano.
	8.	Pes cavus.
	10.	Epithelioma of floor of mouth. Excised.
	17.	Varicose veins. Excised.

CASES UNDER MR. GOLDING-BIRD.

CORNELIUS	3.	Concussion.
	15.	Fractured tibia and fibula.
	17.	Fractured femur.
LUKE	8.	Tuberculous testis. Excised.
	10.	Prolapse of rectum.
	14.	Hæmorrhoids.
	20.	Nephralgia. ? Renal calculus.
CHARITY	7.	Tuberculous mastitis.
	8.	Membranous colitis.

CASES UNDER MR. JACOBSON.

ASTLEY-COOPER	14.	Compound fracture of tibia.
	21.	Lacerated wound of buttock.
CORNELIUS	3.	Fractured patella. Wired.
	5.	Crushed foot. Pirogoff's amputation.
	10.	Pott's fracture.
NAAMAN	4.	Dorsal caries. Abscess.
	8.	Mastoid abscess. Antrectomy.
	14.	Hæmaturia. ? Carcinoma of prostate.
DORCAS	2.	Strangulated femoral hernia.
	12.	Recurrent sarcoma of thigh. Amputation at hip-joint.
	15.	Epithelioma of tongue.
	17.	Suppurating infantile hydrocele.

CASES UNDER MR. SYMONDS.

LYDIA	19.	Hæmorrhoids.
JOB	14.	Varicose veins. Excised.
	18.	Chronic laryngitis. ? Syphilitic.
SAMARITAN	10.	Fistula in ano.

CASES UNDER MR. LANE.

MARTHA	11.	Chronic ulcer of leg. Skin grafting.
LAZARUS	11.	Inguinal hernia.
	13.	Ununited fracture of femur.
PATIENCE	15.	Suppurating palmar bursitis. Incised.
SAMARITAN	9.	Cellulitis of arm.

CASES UNDER MR. DUNN.

LUKE	1.	Genu valgum.
	2.	Carcinoma pylori.
CHARITY.	20.	Tuberculous cervical adenitis.
	22.	Epithelioma linguæ.
PATIENCE	1.	Mammary abscess.
SAMARITAN	7.	Erysipelas of arms and trunk.

CASES UNDER MR. FRIPP.

NAAMAN	20.	Mastoid abscess. Antrectomy.
DORCAS	21.	Sinus following nephrorraphy.
PATIENCE	14.	Cellulitis of face.

A Case of Simple Posterior Basal Meningitis.

MAUD EMILY B., æt. five months, was admitted into Mary ward, under Dr. Perry, for the following condition:—Twelve days before admission patient, who had previously been a healthy child, was seized with a sudden tonic convulsion. The head was thrown back and the legs extended. The child rapidly became drowsy, screaming out only at long intervals, between which it would lie quite quiet. The mother kept her at home for twelve days, during which patient vomited continually and began to lose weight. The family history says that one child had died of "fits" and one of pneumonia. From birth patient has had a discharge from one ear.

Condition on admission.—Pulse 116; respiration 32; temperature 103·6° F. The child was lying in bed with its head moderately retracted and the eyes wide open. It made no sign when the bedclothes were disturbed. The legs were drawn up to the abdomen. There was no rigidity of the limbs and no obvious paralysis. While both pupils were equal and slightly contracted they reacted normally to light. Reaction to accommodation could not be obtained, and the child would not blink when the hand was brought suddenly against the eyes, unless one of the eyelashes were touched. Bright lights did not affect it either, and it was subsequently confirmed that the patient was blind. On examination with an ophthalmoscope both retinæ and optic discs appeared quite normal. In addition there was marked internal squint of the left eye, but nystagmus, often a marked feature of this disease, was absent. The otorrhœa, of which the mother was quite sure, must have stopped suddenly, if it really existed, for none was noticed in hospital. The knee-jerks were always present and slightly exaggerated. One side of the face also was markedly flushed. The respiratory, circulatory and urinary systems were normal, while in the alimentary systems diarrhœa was the only abnormal condition. The abdomen was not retracted but subsequently fell in with the general wasting. The child had a peculiarly shaped head, the measurement from the glabella to the top of the head was, comparatively, very small, while the occipital region was very well developed. The vomiting was not a marked feature.

Progress of case.—During the next two months there was very little change to be noted in the signs. The child steadily lost weight at the rate of two pounds a week. The temperature, after oscillating for a week, slowly fell to 90°, and, with a few sudden rises to 103°, continued subnormal. The pulse was always regular. Cheyne-Stokes breathing was observed on many occasions. The most marked feature during all this time was the cervical retraction. This was often very evident, while on other occasions it would hardly be present. The pupils were often unequal, but never, even towards the end, was any change observed in the discs, and convulsions were entirely absent after the initial attack. On March 26th the child suddenly grew much worse. Its face, which had always been flushed, was now pale, and wore a pinched expression. Death took place on the 28th, just eleven weeks from the commencement of the illness.

Diagnosis.—It was important to arrive at a correct diagnosis of the form of meningitis, since the prognosis is largely affected thereby. Many more children recover from simple posterior basic meningitis than from some other forms, and many often regain their eyesight. The diagnosis lay between a marasmic baby with a retracted head and a form of meningitis not tubercular. The correct result was arrived at from a consideration of the following facts:—

(i.) Age, the patient being under one year.
(ii.) The marked cervical retraction.
(iii.) The presence of blindness with a normal eye-ground.
(iv.) The duration of the illness, extending into the twelfth week.

Abstract of the post-mortem report.—Lungs and heart healthy. Liver 196 grms.; some light areas scattered through the substance. Brain 150 grms. Meningitis at base of cerebellum and around medulla and pons. The lateral ventricles were enormously dilated, so that the cortex was flattened. The fourth ventricle was dilated. The vein of Galen was obstructed by the lymph, thus causing the hydrocephalus. The cerebro-spinal fluid was sterile on cultivation, but the diplococcus pneumonia was discovered in the lymph. There were no tubercles anywhere. Kidneys 48 grms.; heart 38 grms.; spleen 22 grms.

H. W. B.

The Aetiology and Prognosis of Epithelioma of the Tongue.

[Read before the Physical Society by Mr. F. G. Gibson, and received the Society's Prize.]

(*Concluded.*)

I had hoped to have collected some cheerful information as to the proportion of fatal operations in the hospital during the five years taken; but, as I worked out my results I rather lost my optimism; in all 88 cases were operated on, and death was the immediate result in 15 cases, giving a mortality of 17 per cent. Taking the operations in Billroth's Klinik, we find a mortality of 22·6 per cent.; this includes all his operations during the years 1860–1880 inclusive. From the University College Hospital collection of Mr. Barker, including 38 cases during the years 1871–1881, the mortality was 26·3 per cent. In Whitehead's series of 28 cases of his own operation by different surgeons, he computes the mortality at 21 per cent., while of a total of 218 individuals who underwent operation for extirpation of cancer representing the work of several German and English surgeons over a period of some twenty years, the average mortality was 16·9 per cent., or almost identical with that of our own hospital during the last five years. It is

thus seen that while during the last twenty years there has been some decrease in the mortality after operation, this diminution has not gone on so far as the cases are concerned in which we are immediately interested. I think this result may be due to a desire on the part of the surgeon to secure a radical cure of the disease, as the 15 fatal cases collected by me have all been of a most severe character. The special dangers in operations on the tongue are (1) bleeding, (2) sepsis of the pyæmic form, (3) lung affections, produced by the mechanical entrance of blood, food, or foul matter into the air passages. The last is undoubtedly the most important, and of the 15 fatal cases at the hospital, 13 of the deaths have apparently been due to septic broncho-pneumonia; one of these had a secondary growth in the anterior mediastinal glands. Of the remaining two cases one apparently died from softening of the brain after ligature of the common and external carotids; the other was found post-mortem to have an adherent pericardium, and also had had his external carotid ligatured. Both of these succumbed before broncho-pneumonic symptoms could have occurred. Of the seven cases admitted to the hospital, and not operated on, I can only trace one who reports himself doing fairly well after three years and seven months have elapsed. I may point out that the lip was primarily involved in this case, although the lingual tissues were apparently infiltrated; the other six cases are unknown at the old address, and are, doubtless, dead. Of the 88 cases operated on, I can account for 69; 15 did not recover from the immediate results of the operation, 42 have since died, and may be placed in two classes, (1) those who were subsequently operated on for recurrence, and (2) those who did not undergo further operation; while 12 have either been seen by me, or have reported themselves free from recurrence. Of these 12, one has undergone, at short intervals, two operations for recurrence in the glands, since his original operation in September, 1898 (No. 91), and I am afraid he cannot be considered a complete success. The remaining 11 have had no recurrence, and have lived on the average thirty-four months; it is scarcely fair to compare this with the average life of the patients not operated on, which is scarcely six months, for it must be remembered that the cases cured were probably taken early enough, while those who died without operation in a few months, were beyond hope of succour on admission. I may add that of the cases considered cured, not one showed any implication of the glands.

As to the date at which the salivary and lymphatic glands are implicated, it is difficult to make a definite assertion; glands are often found infiltrated with growth during an operation, which were not evident on palpation, and moreover, glands which are manifestly enlarged are found on microscopical examination to show no evidence of malignant growth, but only an inflammatory infiltration of small round cells. I find definite mention of glandular enlargement in 57 cases out of the total of 95, and this enlargement was noticed on the average within eight months of the appearance of the primary lesion, although some of the cases with a history of a year or more showed no apparent increase in the size of either salivary or lymphatic glands. I think that the average time which is usually given as ensuing between the appearance of the sore, and the enlargement of glands, namely, six to eight months, is in accordance with the data I have adduced.

Again, there is the question as to whether operation prolongs life where recurrence takes place. It is a rule that recurrence occurs in the stump or cervical lymph glands within a year of the operation, and my collection of fifteen cases of recurrence makes the interval even shorter, but it is equally true that the growth seldom recurs in the stump of the tongue as an ulcer; its malign influence is directed rather to the glands and deep structures. From an examination of cases subsequently operated on in the hospital, I can only find one of a further resection of a stump on account of ulceration.

From a list of 49 cases collected by various authors as not operated on, the average life is found to be 11·7 months, while the average duration of life in 54 cases operated on stands at 19 months, showing a clear gain from operation of 7·3 months. My own list gives an average duration of life in 37 cases operated on of 15 months, so my results bear out those already quoted. Again, there is the question as to whether subsequent operation prolongs the patient's life after recurrence has occurred in the glands. I find that in the cases in which recurrent invasion of glands was treated at the hospital, the average life since initial appearance of growth was 19 months, or since operation 17·4 months, while in the cases who did not subsequently attend the hospital for treatment the corresponding figures are 15 and 10 months respectively, showing again a clear gain of seven months, but you must remember that I am dealing with small groups of cases which may give a fallacious average.

Finally, as to the success of various modes of operation, I find that out of 41 cases in which only a portion of the tongue was removed the deaths numbered three only, and each case had special features of danger, *vide* Nos. 13, 34 and 38.

Where the whole tongue was removed there was a mortality of 1 in 9; and where tongue and glands were removed at one operation, 11 patients succumbed out of 31 cases operated on, while when their removal was extended over two operations, there was an absence of mortality in a total of 8 cases. The majority of fatal cases, therefore, were, as one would expect, those of extensive growth with gland infiltration, which demanded necessarily drastic treatment. I had intended to classify the forms of operation in more detail, but time and space are wanting, and it is difficult to arrange in classes methods of operation which, though based on classical lines, yet show, more than any others, the personal equation of the operator, and the exigencies of case and circumstance.

To recapitulate, then, I think I have corroborated the following facts:—

1. That fruitful sources of epithelioma are habits of smoking and the presence of carious teeth.

2. That the male cases amount to 90 per cent of the total.

3. That the disease is most prevalent between 50 and 60 years of age.

4. That the margins of the tongue are, in the majority of cases, earliest affected.

5. That the primary lesion is of a painless and apparently trivial nature.

6. That syphilis must be regarded as an important factor in the disease.

7. That the glands are enlarged in the majority of cases, and can be felt on the average within eight months of the appearance of the primary lesion.

8. That the operation fatality amounts to about 17 per cent. of the cases operated on, death being usually due to septic broncho-pneumonia.

9. That about 10 per cent. may be considered permanently benefited by operation.

10. That even in serious cases operation prolongs life on the average about fifteen months.

11. That patients who undergo subsequent operation for recurrence show an average gain of about six months of life.

I can only close my remarks with the hope that I have not wearied you, and with the feeling that if I have provided profitable matter for thought and discussion, with a view to elucidating some of the mystery that envelopes a most dire disease, my labour, and your patient hearing, have not been in vain.

LIST OF CASES.

(Abridged from Mr. Gibson's original Tables.)

In the following list the number of case is given in type, thus (1); the sex is expressed by the letter M (male) or F (female); the age is given in italics, thus (*62*); the previous duration of the disease is expressed in months by Roman numerals, thus (VI.). The symbols Sy. (Syphilis), Phth. (Phthisis), T. (carious or jagged teeth), S. (history of much smoking), H. (history of heredity), are used with reference to the ætiology of each case. Complete and incomplete refer to the degree of extirpation of tongue.

1	M.	*62*	VI.	Glands enlarged	T.	No operation	Result, ?.
2	M.	*58*	III.	No glands	S.	Incomplete	Lived 43 months.
3	M.	*67*	IV.	Glands	Sy. S.	Incomplete	Result, ?.
4	F.	*45*	II.	Glands	T.	Incomplete	Lived 15 months.
5	M.	*65*	X.	No glands	S. (?)	Incomplete	Result, ?.
6	M.	*51*	VI.	Glands	H. Sy. (?) T.	No operation	Lived 12 months,
7	M.	*59*	II.	No glands	T.	Complete	Died immediately.
8	M.	*54*	II.	Glands	Sy.	Incomplete	Result, ?.
9	M.	*50*	6 weeks	Glands	S.	Complete	Lived 11 months.
10	M.	*54*	6 weeks	Glands	Sy.	Complete	Lived 12 months.
11	M.	*61*	10 weeks	Glands	S.	Complete	Lived 9 months.
12	M.	*53*	10 weeks	No glands	H. Sy.	Complete	Result, ?.
13	M.	*65*	III.	No glands	S.	Incomplete	Died immediately.
14	M.	*46*	XXXVI.	Glands	S.	Complete	Well 3 months after.
15	M.	*53*	I. (?)	Glands	Sy. (?) S. T.	Complete	Died immediately.
16	F.	*50*	XXIV. (?)	Glands	H. Sy. (?)	Refused op.	Result, ?.
17	M.	*45*	III.	Glands	S. T.	Complete	Lived 13 months.
18	M.	*60*	V.	Glands	Sy. (?) T. S.	Incomplete	Result, ?.
19	M.	*60*	VIII.	No glands	S. T.	Incomplete	Lived 13 months.
20	M.	*63*	VIII.	Glands	H.	Complete	Died immediately.
21	M.	*54*	VI.	Glands	S. T.	Incomplete	Lived 18 months.
22	M.	*45*	XII.	Glands	S. T.	Complete	Died immediately.
23	M.	*55*	? ? 2 weeks	Glands	Sy.	Complete	Complete recovery.
24	F.	*45*	III.	No glands	Phth. T.	Complete	Lived 10 months.
25	M.	*40*	VI.	Glands	T.	Incomplete	Lived 18 months.
26	F.	*70*	I.	No glands	Sy.	Incomplete	Complete cure.
27	M.	*54*	II.	Glands	Sy. (?)	Incomplete	Lived 11 months.
28	M.	*43*	V.	Glands	Sy. T.	No operation	Lived 13 months.
29	M.	*55*	?	Glands	Phth. S. T.	Incomplete	Result, ?.
30	M.	*60*	XXIV.	Glands	T.	Incomplete	Died immediately.
31	M.	*68*	?	Glands	Sy.	Incomplete	Result, ?.
32	M.	*63*	IV.	Glands	Sy. (?) S. T.	Incomplete	Lived 18 months.
33	M.	*42*	VII.	No glands	T. S.	Incomplete	Lived 13 months.
34	M.	*53*	XII.	No glands	T.	Incomplete	Died immediately.
35	M.	*58*	?	No glands	S.	Complete	Result, ?.
36	M.	*74*	III.	Glands	—	Incomplete	Result, ?.

37	M.	51	XII.	Glands	S. T.	Incomplete	Result, ?.
38	M.	49	IV.	Glands	Phth. H.	Incomplete	Died immediately.
39	M.	57	I.	Glands	—	Incomplete	Lived 13 months.
40	M.	76	XVIII.	No glands	T.	Incomplete	Result, ?.
41	M.	54	IV.	No glands	—	Incomplete	Result, ?.
42	M.	56	III.	No glands	S.	Incomplete	Lived 16 months.
43	M.	57	VI.	No glands	T.	Incomplete	Result, ?.
44	M.	53	VI.	No glands	Sy. T. S.	Incomplete	Lived 6 years 8 months.
45	M.	48	I.	Glands	Sy. T.	Incomplete	Lived 9 months.
46	M.	76	III.	Glands	—	Incomplete	Result, ?.
47	M.	50	?	Glands	S. T.	Incomplete	Result, ?.
48	M.	50	IV.	No glands	—	No operation	"Well" after 4 years.
49	M.	69	I.	Glands	S.	Complete	Result, ?.
50	M.	62	II.	No glands	Sy.	Incomplete	Lived 13 months.
51	M.	48	II.	Glands	—	Complete	Lived 7 months.
52	F.	72	IV.	No glands	T.	Incomplete	Lived 11 months.
53	M.	63	I.	No glands	Sy. S.	Complete	Lived 8 months.
54	M.	47	III.	Glands	H. T.	No operation	Lived 6 months.
55	M.	55	Old standing	No glands	Sy.	Incomplete	Result, ?.
56	M.	65	IV.	No glands	Sy.	Complete	Lived 16 months.
57	F.	61	XXIV.	No glands	Sy.	Complete	Well 4 years after.
58	M.	56	III.	No glands	Phth. S. T.	Incomplete	Well 4 years after.
59	M.	54	II.	Glands	H. S. T.	Incomplete	Died immediately.
60	M.	54	XXIV.	Glands	T.	Incomplete	Lived 37 months.
61	M.	50	III.	Glands	T.	Incomplete	Lived 16 months,
62	M.	54	VI.	Glands	T.	Incomplete	Result, ?.
63	M.	67	XXIV.	Glands	S. T.	Incomplete	Died immediately.
64	M.	55	IV.	Glands	—	Incomplete	Lived 20 months.
65	M.	47	XII.	Glands	—	Complete	Lived 20 months.
66	M.	55	IV.	Glands	Sy.	Incomplete	Lived 11 months.
67	M.	57	VIII.	Glands	H.	Incomplete	Lived 17 months.
68	M.	69	II.	Glands	Sy. S.	Incomplete	Lived 26 months.
69	M.	56	IV.	No glands	S.	Incomplete	Result, ?.
70	M.	64	II.	No glands	—	Incomplete	Result, ?.
71	M.	46	IV.	—	Sy. T.	Incomplete	No return 3 years.
72	F.	30	VI.	Glands	T.	Complete	Lived 7 months.
73	M.	48	VIII.	No glands	Sy. (?) S. T.	Incomplete	Lived 12 months.
74	M.	54	IV.	No glands	H. T. Sy.	Incomplete	Died 3 years after.
75	M.	64	VI.	No glands	Sy. (?)	Incomplete	Lived 20 months.
76	M.	78	IV.	No glands	Sy. (?) T.	Incomplete	Lived 17 months.
77	M.	52	I.	No glands	Sy. T.	Incomplete	Lived 20 months.
78	M.	75	XII.	Glands	Phth. S. T.	Incomplete	Died immediately,
79	M.	49	I.	Glands	S.	Incomplete	Well 2 years after.
80	M.	57	VI.	No glands	Sy. S. T.	Incomplete	Died immediately.
81	M.	53	I.	No glands	—	Complete	Well 2 years after.
82	M.	59	III.	No glands	Phth. T.	Incomplete	Lived at least 6 months.
83	M.	40	XVI.	No glands	—	Incomplete	Well 2 years after.
84	M.	63	II.	Glands	Sy. T. S.	Incomplete	Lived 7 months.
85	F.	62	II.	Glands	H. T.	Incomplete	Result, ?.
86	M.	55	VI.	Glands	S. T.	Complete	Died immediately.
87	M.	68	III.	No glands	S. T.	Incomplete	Lived 19 months.
88	M.	57	III.	Glands	S. T.	Incomplete	Lived 6 months.
89	M.	53	III.	Glands	S. T.	Incomplete	Result, ?.
90	M.	39	XII	Glands	Sy. S.	Incomplete	Result, ?.
91	M.	35	VI.	Glands	H. T.	Incomplete	Well 15 months after.
92	M.	52	II.	Glands	Sy. S.	Incomplete	Died immediately.
93	M.	62	XIII.	Glands	—	Incomplete	Well 20 months after.
94	M.	69	II.	Glands	T.	Incomplete	Result, ?.
95	M.	54	XVIII.	Glands	Sy. T. S.	Complete	Died immediately.

Some Notes on the Imperial Yeomanry Hospital.

Imperial Yeomanry Hospital,
Deelfontein,
April 23rd, 1900.

Our last medical officer, Barclay Black, has arrived since my last letter; he joined us from New Zealand. That brings the strength of our medical staff up to nineteen, including Colonel Sloggett, but as three of them are specialists, namely, the skiagrapher, Mr. Hall-Edwards, the ophthalmic surgeon, Mr. Cargill, and the dental surgeon, Mr. Newland-Pedley, and as Colonel Sloggett's time is of course entirely taken up by army matters, it leaves us only fifteen effective medical officers, which is five below the strength of an ordinary military base hospital. True, we have ten senior medical students in addition, but on the other hand we have a very great deficiency of orderlies as compared with a military hospital, a deficiency of sixty at least, which is not altogether compensated by the twenty extra nurses we possess.

Our 520 beds are now open, and we can just run them comfortably with our present staff, but it will not be long before we shall have to increase our accommodation to 750 or more, and to serve that large number of beds with our comparatively small staff (which we have no means of increasing) will tax the energies of everyone.

Every single hospital in South Africa, whether it is a 100 bed field hospital, or a 200 bed stationary hospital, or a 520 bed base hospital like our own, is called upon to accommodate an increase of 50 per cent. at least over and above its designed capacity.

I am sorry to say that we are about to lose one of our sisters. She has been ill ever since she left England, and despite the fact that an operation directly she arrived here gave her considerable relief for a time, she has developed symptoms which make it certain that she will not recover her strength in time to be of any practical use on the staff, and it seems better from every point of view that she should follow her inclination and go home.

We have been rather bothered of late by petty looting on the part of some of the blacks employed in our service, but I think that it will not be difficult to stamp it out. Among other things three rifles were found the other day in their camping ground, some quarter of a mile from our huts, buried beneath their fire-places, which seem to be the sites they generally choose for concealing loot.

During the past week we have had quite a brilliant run of operations for the removal of bullets from various parts of the body. Head, neck, trunk, and extremities, have all contributed their share. The operating theatre here is the envy of the many surgeons who look in upon us on their way up and down country.

There are two civilian medical officers in the hospital as patients at the present time. They come from Bloemfontein, and they agree with all other reports we have received in saying that Bloemfontein is at present very far indeed from being the healthy spot that it is described in the papers—so much so that I am extremely glad that we were not sent there.

H.R.H. the Prince of Wales's flags arrived a fortnight ago, but we have only just succeeded in getting sufficiently high flag posts to display them properly. They are a most attractive combination of his racing colours, with a red cross on a white ground in the middle, and with the flags of the Red Cross Society, with an all-white ground, which fly from the other parts of the Hospital grounds, they are most effective.

We make a point of keeping up the open-air concerts, for they are evidently very much appreciated by all the various classes represented in our camp. Several of the medical and nursing staff are good performers. There is a little music with the piano practically every night in the officers' mess, and it can be heard in a subdued way over most of the hospital grounds on a still night, and seems to give pleasure to the patients.

It is perfectly marvellous how much ground patients gain here in a few days. Three or four days after admission you often would hardly recognise them as the same pitiable beings who limped or were carried in from the ambulance trains.

Douche, the French cook, who came out on purpose to cook for the patients, is admirable. Out of the most unpromising materials he evolves most excellent soups, stews and puddings, and the air is of a nature which soon enables the patients to do ample justice to his dishes. It is perfectly extraordinary the amount they can get through at their midday meal, that is, of course, those who are not on special diets. All our kitchen equipment has not yet arrived, and he still has to cook among the karroo bushes and boulders, for the permanent kitchen which is erected is still occupied by beds. However, nothing daunts him, and he emerges smiling from thunderstorms and doesn't seem to mind a bit having to make his soups in galvanised zinc baths.

It is very striking how delighted all the patients are, officers and men alike, to find themselves once more able to get some sweets. We are able to give them jam pretty liberally, and they consume enormous quantities of sugar, and any little extras such as lolly-pops, or more especially chocolates, are run after by these stern and tired warriors almost as if they were gluttonous little children. I wish some of our friends would send us out supplies of sweets of all kinds, but especially chocolates. I think it is not too much to say that most of them would rather have a tin of chocolate than a tin of tobacco given to them, though their delight at having the latter again within their reach, and their surprise that they do not have to pay for it is most refreshing to behold.

Coal is very expensive here, and oil is very, very difficult to get, and the scarcity of it gives rise to considerable difficulty, for, of course, there is great demand for light in the many tents and huts.

The laundry is at last in full working order. Miss Cheeseman and four of her ward-maids do the lighter

work, the heavier being done by blacks, and the machinery being managed by two men who came for this purpose. We have had considerable difficulties to overcome, for the washing runs up to a very large weekly total in so big a camp.

We have a large amount of enteric fever here now, and of course great care has to be taken in the isolation and the disinfection of all the linen and utensils from the enteric huts. This disease ought to be diminishing soon with the advent of cold weather, but its place as the main scourge of the troops will probably be taken by pneumonia.

Imperial Yeomanry Hospital,
Deelfontein,
May 7th, 1900.

We are still very full here, except in the two huts which we always reserve for yeomanry. These are not more than half full, but almost every day a few yeomen come in. We find that patients generally prefer the tents to the huts, except when they are really gravely ill. They have a feeling of greater freedom under canvas.

Our field hospital has passed up-country. They spent some hours with us before resuming their journey to Springfontein, which, as far as they knew, was to be their destination. We rather hope that they may have got up in time to be included in Lord Roberts' advance.

We have managed to manufacture a fairly respectable cricket ground here. The pitch, of course, is of matting. Fielding is made possible for a few yards round the wickets, but beyond that it is very rough, for nothing has been done to the ground beyond the removal of boulders and karroo bushes, thus leaving an irregular and wholly grassless surface. The Bedfordshire regiment have been to play a match with us, and to-day a team of our men has gone to De Aar to play the civil and military club there. I am afraid they will not have had much time for play, for the train which was to have taken them away on their one and a half to two hours journey at nine o'clock in the morning, did not leave here until one o'clock. Such are the irregularities of the railway service. It is pitch dark out here now by 5.30, sunset being at five and twilight always extremely short. We are still having lovely weather, about as hot in the sun as a really hot summer's day in England, and the cold nights which seemed to have set in a short time ago have been absent of late. For days together we do not see a cloud, unless indeed it be a cloud of locusts. These insects are always with us, sometimes in small numbers but sometimes in veritable clouds, of which we have taken some excellent photographs. In the bright sunshine they look almost like a heavy fall of large-flaked snow. They settled on and around our camp the other day, more around than on, and ate up what little small shoots of new grass there were, and the young green sprouts of the Karroo bushes which had just been tempted into fresh growth by the recent rains.

The verb "to steal" does not exist apparently in the vocabulary of this country. Its place is always taken by "to commandeer" except when a black does it. Everybody seems to think that there is nothing wrong in commandeering just whatever they require if they see an opportunity, and if one man's bath, or lamp, or blankets have been commandeered by somebody else, he at once commandeers the first substitute for the missing article that he comes across. It seems to be an entirely natural step that leads to an almost complete extinction also of the word "truth," and you may possibly think that I am suffering from an attack of this prevailing mental disease, when I tell you that yesterday an ordinary railway train was stopped by locusts; but it is a fact nevertheless, for sitting on the metals, the warmth of which appears to be seductive to them, they get crushed by the wheels and so lubricate the surface to such a degree that an engine is rendered unable to climb a steep gradient.

Speaking of amusements reminds me that a few nights ago a new hut which was to be filled next day from a hospital-train, tempted us to push aside the 34 bedsteads and to have an impromptu dance. I think it did good to everybody who came. Certainly it was hugely enjoyed by one or two of the local farmers and their wives and children. The wounded officers attended fully arrayed in their splints and bandages, and dancing was kept up until the giddy hour of 10.30 p.m.

By the bye it is on Saturday, at two o'clock, that our weekly convalescent train leaves for Cape Town.

The growth of the hospital goes on most satisfactorily. I still think that we shall be fully and completely established by the 1st of June, which will be five months, not six, as I erroneously stated in my last letter, from the date of the first inception of the Imperial Yeomanry Hospital.

A. D. FRIPP.

Papers by Guy's Men.

Bacterial Vaccines and Antitoxic Sera. By Walter C. C. Pakes, D.P.H. Camb.—*Clinical Journal*, May 2nd.

Treatment with Antistreptococcic Serum. By J. W. Washbourn, M.D., F.R.C.P.—*Ibid.*

The Separation of Albumin from White of Egg. By F. Gowland Hopkins, M.A., M.B.—*Journal of Physiology*, May, 1900.

The Imperial Yeomanry Hospital. By Alfred D. Fripp, M.S. Lond., F.R.C.S.—*Lancet*, 26th May and 2nd June.

A Lecture on the Operative Treatment of Simple Fractures. By W. Arbuthnot Lane, M.S. Lond.—*Ibid.*, May 26th.

A Clinical Lecture on Carcinoma of the Pancreas. By W. Hale White, M.D., F.R.C.P.—*Clinical Journal*, June 6th.

The Surgery of the Internal Semilunar Fibro-cartilage. By W. Arbuthnot Lane.—*Ibid.*

Passim.

WITH this number of the GAZETTE we issue the promised photograph of the late Mr. Davies-Colley. The picture forms a companion to that of Dr. Pye-Smith, published some little time since. It is hardly to be expected that everyone will agree in considering the reproduction lifelike; indeed, in this respect the selection committee showed a very marked difference of opinion, each individual member finding the best echo to his memory in a different photograph. Agreement was finally obtained, but the incident was instructive in that it foretold a like difference of opinion among Guy's men in general. For our own part we think the likeness is excellent, but for one thing, and that is the touch of sadness which was absent from the face we all knew so well.

IT is officially announced that the Annual Prize-giving will be held on July the 4th. We understand that the function will not this year be known as a garden party; the large stores of building material in the park effectually obscure the remotest semblance to a garden. Various more or less appropriate names suggest themselves in connection with this entertainment, but most probably the difficulty will be shelved by a discreet silence on the nature of the show. Although the space reserved for the "Sisters and Nursing Staff" has not been attacked by the builders, or rather, has recovered from the effects of the conduit excavations, there is a noticeable absence of the other sex in the enclosure. This leads one to suppose that the grass is to be kept untrammelled for the coming "wayzgoose," and that there is to be an open-air element in the proceedings after all. It seems, however, a pity that the Nurses, if this be the case, should be deprived of their much appreciated garden to the doubtful advantage of some summer visitors. The sun-baked flat of the Nurses' temporary home can never be as suggestive of pastoral delights as the real turf, the real sparrows, and Mr. Betts' real pigeons.

THE Secretaries of the Athletic Club have sent us a letter in which they emphasize the necessity for support in the forthcoming Athletic Sports. As announced in our last issue, the 21st inst. is the date of the afternoon meeting, that is to say, less than a fortnight hence, and yet the entries—real entries, backed by a determination to compete—are very few, and there is no immediate prospects of any elevation from the dead level of slackness reached last year. The fixation of standards in certain events, notably those in which competition has been of the weakest, may go some way to ensure a reasonable degree of efficiency. Of late years, our high-jump, hurdles, and kindred events have been unworthy of small school sports, and if the committee succeed in forcing some sort of decent competition in these events, they will deserve well indeed of the hospital.

EVERYBODY, with very few exceptions, is capable of doing something in the athletic line, and many men whose doings at school have been only of the very moderate order, find that with increased years their powers also have increased with more than equal rapidity, and that they are capable of performances which are quite respectable and sometimes even good. It is these men whom the athletic club seeks to reach, and the only way in which their value can be estimated is by competition in the sports. Every Guy's man would like to see the Athletic trophy again in the smoking-room, and every man should do what lies in his power to further this end. Entries are still received, therefore enter and compete, for your own advantage and the glory of the hospital.

So far as the Cricket Cup is concerned, our hopes are dead for yet another year. On paper, the team looks good enough in batting, and very fair in bowling, yet on a good wicket, with the advantage of "first knock," we only succeeded in putting up a small score, and failed to prevent our opponents from running into the second century. In cricket, more than in anything else, prophesy is doomed to failure, and a decisive victory may, with the same teams, be exchanged for a crushing defeat. While in no sense attempting to detract from the merits of the St. Mary's Eleven, to which our team went under, we do not think that Guy's did herself justice, and another day might see the result the other way. Meanwhile we look forward to a successful season albeit without any further Cup interests.

WE have received the *Physician and Surgeon* for the week ending May 31st, in which several photographs appear illustrative of life at the Imperial Yeomanry Hospital, Deelfontein. One picture is that of a group of the staff in which many familiar Guy's faces occur. Perhaps

familiar is hardly the right word in this case; the semi-military garb of many of the men makes recognition at first somewhat difficult, but as the eye becomes accustomed to the novelty of the surroundings, the faces gradually assume well-known shapes, and then the likeness becomes obvious. It would be invidious to mention any particular persons, but Dr. Bruce looks perfectly sweet in a C. I. V. hat, and Mr. Greenfield's costume is highly suggestive of a stage bushranger. By the way, Mr. Fripp writes that the health of all the Guy's contingent is excellent, and includes in the bulletin the names of Civil-Surgeons Starling and Stamford, and Captain Brailey, C.I.V., who have been patients of the hospital.

THE Inter-Hospital Chess Tournament has come to a curious finish. Each competing hospital has scored one and a half points, thus making the result a draw all round. The only solution to the difficulty lies in the complete replaying of every contest, a consummation too appalling to be considered. The impartial observer cannot fail to be struck by the fact that the Guy's men have not lost a match; at the same time they have not won a match, which detracts somewhat from the beauty of their performance. Somebody must keep the cup for the year, and if no other means suggests itself, they might do worse than leave it to chance, and go "odd man out," odd man to keep the cup.

AN old number of this GAZETTE, No. 12, December, 1876, has been unearthed from the Porter's lodge, and now lies before us. There is much in it of interest to every class of reader. The sporting man will find an account of a football match with Blackheath, in which the result was a "draw in favour of Guy's by two touch-downs to one." An account of a dinner of the "Junior Guyite Club," shows that the pet aversion of the much-lamented *Guyoscope*, the "Guyite," existed a quarter of a century ago. Finally, in the editorial—there is no "Passim" in the number—the GAZETTE makes an earnest appeal, which, to the present generation, seems almost ludicrous. "Guy's will attract the best men when the advantages she offers are decidedly in advance of other schools. Already in some subjects she offers the most undoubted advantages, with which other schools would find it vain to compete, and year after year she is making her class-teaching more efficient. Her most pressing want is an Histological Laboratory with an Assistant Demonstrator to aid the Students, and this want we hope the Authorities will quickly supply."

THE partial eclipse of the sun was duly observed in the Hospital, and on every hand groups of men were found conning the sun's disc through bits of smoked glass. Even in the wards work was suspended for a moment and everybody did a little bit of sky-gazing.

APPARENTLY there is no dearth of shooting men in the hospital at the present moment, but the practice cannot be considered satisfactory. The new regulations of the N.R.A., by which men fire standing at 200 yards, and from the knee at the five hundred distance, cannot fail to detract from the number of high scores. A significant fact, however, is evident from the manner in which some of the schools have improved their shooting this year—relatively of course—and it is that accuracy depends largely on the too much neglected musketry drill. Steadiness, standing and kneeling, can only be obtained by frequent and assiduous exercises in the firing positions. In schools this is compulsory, and if we are to stand any chance in the United Hospitals competition at Bisley, the member of the team must pay some attention to the much neglected drill-book.

ONE of the first to enter Mafeking after the raising of the siege was an old Guy's man, Dr. William Davies, son of Mr. E. Davies, the Medical Officer of Health for Swansea, and one of the Johannesburg residents who were imprisoned by ex-President Kruger for supposed implication in the Jameson Raid. At the outbreak of hostilities Dr. Davies joined the Imperial Light Horse, and in course of time found himself besieged in Ladysmith. After the relief of this town, he proceeded, as Surgeon in charge of the medical stores, with the relief column to Mafeking, and thus came to take part in the victorious entry.

CONGRATULATIONS to Messrs. Dunston, Owsley, Miller, Fraser, and Turner, on the M.B. Lond., and to Mr. W. C. C. Pakes, on his election to the fellowship of the Sanitary Institute.

IT is very surprising to find that a large number of men are absolutely ignorant of all matters connected with bunting, British and Foreign. By now we are all conversant with the proper arrangements of the stripes in the Union Jack, and some of us can spot a red ensign when we see one. Few, however, apparently realised the meaning of the flags which were hoisted on Pretoria day over the Front Gate. The big white ensign was run up as a delicate compliment to the Naval Brigade, and incidentally because it was the only flag the marine storekeeper had in stock. The thing underneath is a Transvaal flag, hoisted half-mast high and reversed, and adorned with crêpe.

THE Biennial Dinner has been arranged for the 6th of July, in the Whitehall Rooms, Hotel Metropole. Mr. Higgens will take the chair, and it is expected that there will be a large muster of both past and present students of the hospital. The honorary secretary, Mr. Charters J. Symonds, 58, Portland Place, W., will be glad to receive the names of all men who wish to attend.

Reviews.

The Century Invalid Cookery Book: For the use of Nurses in Training Schools, Nurses in Private Practice, and others who tend the sick. By Mary A. Boland. (T. Fisher Unwin, Paternoster Square). 1s. net.

This work should prove of great value to nurses generally. The recipes have been carefully chosen, and detailed descriptions are given in order that those who know nothing of cooking may be able, by intelligently following the instructions, to make acceptable dishes. Much useful knowledge is contained in this book with regard to the preparation and daintly serving of food, while the information on the feeding of children is of especial value.

Messrs. Jarrold & Co., of Warwick Lane, E.C., have published a new Nurses' Report Book, containing forms for half-hourly observations for a period of a week. The special features of this publication are the detailed and comprehensive headings, the specification of the particular hour at which the note is made, and the differentiation of day and night entries by "diaper" printing, so that one sees at a glance whether the note was made during the day or the night. The same method of distinction is adopted in the four-hour chart which is included in the book. The report book retails at the very modest price of one shilling.

Also received, Treatment, Clinical Journal (4), Hospital (4), Middlesex Hospital Journal, London Hospital Gazette, Broad Way, Therapist, Polyclinic (2), St. Thomas's Hospital Gazette, Le Mois Medico-Chirurgical, St. Mary's Hospital Gazette, St. George's Hospital Gazette, Physician and Surgeon.

Appointments.

CIVIL.

BUSTEED, J. H., L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., has been appointed Medical Officer for the Workhouse and Parish of Ellesmere.

MUNDEN, CHARLES, M.R.C.S., L.S.A., has been re-appointed Medical Officer for the Third (C) District, by the Langport (Somerset) Board of Guardians.

PAKES, W. C. C., L.R.C.P. Lond., M.R.C.S., D.P.H. Camb., has been elected a Fellow of the Sanitary Institute.

RITCHIE, R. H., M.B., has been appointed Health Officer for the Shire of Arapiles, Victoria (Australia).

ROBERTS, J. LLOYD, M.D. Lond., B.Sc., F.R.C.S. Eng., has been appointed Honorary Physician, Stanley Hospital, Liverpool, *vice* R. L. Richardson, resigned.

SHARP, H. C., M.B., has been appointed Medical Officer of Health to the Corporation of Truro.

SHEEN, A. WILLIAM, M.D., M.S. Lond., F.R.C.S., Eng., has been appointed Honorary Surgeon to the Cardiff Infirmary.

SPON, H. J., M.R.C.S. Eng., D.P.H. Camb., has been appointed Visiting Medical Officer to the City Dispensary, College Street, E.C.

TELLING, W. MAXWELL, M.B., B.S. Lond., has been appointed Resident Medical Officer to the General Infirmary at Leeds.

NAVAL.

Surgeon N. L. RICHARDS has been appointed to the *Cormorant* for Gibraltar Hospital, Dockyard and Naval Extension Works.

Pass List.

University of London, May, 1900.

M.B. EXAMINATION.

FIRST DIVISION.—J. T. Dunston.

SECOND DIVISION.—A. Fraser, E. A. Miller, G. C. Owsley, F. D. Turner.

With the Army Medical Corps in South Africa.

(BY OUR SPECIAL CORRESPONDENT.)

(Published by permission of the Director-General of the Army Medical Service.)

Highland Brigade Field Hospital,
Bloemfontein Camp,
Easter Eve, 1900.

Your special correspondent has been posted, at least for the present, with the above hospital, in place of a civilian surgeon who has been sent to Cape Town on convoy duty. Such changes in the composition of a hospital are very frequent in the course of the campaign; and probably few units will have more than about one quarter of their original staff left by the end of the campaign, if they have seen much active service. Even at No. 1 Hospital at Wynberg, only three out of the six original R.A.M.C. officers are now left; and only two out of the twelve original civilians; the rest being scattered to Simon's Town, Natal, Kimberley, and Bloemfontein. In this hospital the Major in command and the Quartermaster (not a medical man) are the only officers remaining of the original hospital; and the hospital itself with the third brigade to which it belongs, having originally belonged to the second division, is now part of the ninth division under General Colville. The other officers of the hospital consist of a second Major, who was through Lord Methuen's battles last year with another hospital, a civilian from Glasgow, who was first in the Orange River stationary hospital, then with mounted infantry, and only joined this hospital at Paardeberg; and fifthly the writer. The way the Glasgow colleague was transferred is interesting, inasmuch as it shews the difficulty of working with mounted infantry. He was engaged in looking after one of the troopers while the regiment continued on their way. It being late in the evening he was unable to rejoin them, and so returned to the nearest camp, when the P.M.O. seized on him as the only medical officer available, and sent him in charge of a convoy of sick and wounded to Modder or Orange River. Naturally enough, when he rejoined his regiment at Paardeberg by dint of journeying through night and day as well, he was reprimanded for not keeping up with his unit; and so it was considered better on all sides that he should be transferred. This incident shows of how little use the regimental doctor with mounted infantry can be, when on the march or in action. Mr. R. B. Stamford, by the way, was attached to a regiment of mounted infantry, No. 5, General Hospital, to which he was originally attached, being broken up and the personnel distributed. Now, however, he has unfortunately been suffering from an attack of enteric fever, and is lying almost convalescent in the Australian hospital (of 100 beds or so) here. He attributes the mildness of his attack to inoculation. He hopes to be sent back to the front before long, after a short visit to Cape Town or neighbourhood.*

A field hospital is supposed to have tents for 100 patients; but when this division went out on duty for a few days recently, the other field hospital of the division went with it, and left its patients to the care of this one. Tents, including those of the officers, have been appropriated for the purpose, and at one time there were 300 patients on hand. Altogether there are something like 1000 sick lying out thus on the veldt, besides nearly 500 in the five buildings of the town, which have been appropriated for hospital work. But this is quite a good thing for the patients. The 1000 out in camp are all sick, and so for the matter of that are most of those left in town, the wounded being shipped off as soon as possible to the fine No. 6 General Hospital of 800 beds at Naauwpoort. And of all these sick patients a large proportion are suffering from enteric fever, which is certainly less dangerous to others, and is probably better treated out in the open than on the floors of little rooms in town. The air here is splendidly fresh; the sun is hot during the daytime, but not oppressive; and when the medical officer goes round his cases at 9 p.m., he finds four out of five fast asleep, even cases with acute fever. With an army of nearly 40,000, sickness of this sort is hardly to be wondered at; and on the whole the epidemic appears to be of a mild type. The patient generally comes after a few days increasing weakness, complaining of headache or pains down the back and limbs. Diarrhœa is uncommon at first, but the pulse is at about 110 to 130. We have to do here without many "necessaries." There is a thermometer famine, and a scarcity of bed-pans, and many drugs; and until our stores arrive by the congested railway we have to make shift—as often on active service. The whole disease is often over in ten days, and patients can then be invalided temporarily to the base for convalescence. The mail is going, and so this letter must come to an end.

Highland Brigade Field Hospital,
Bloemfontein Camp,
April 21st, 1900.

The daily work of a Field Hospital in camp may be of some interest. The orderlies start work in their respective tents under their respective ward-masters at about six o'clock, that is, sunrise. Times are only approximate in camp where there are no clocks. The patients wash a limited portion of themselves as best they can, but as a rule they continue the practice, natural to active service, of sleeping in their clothes, and washing is of necessity limited, since Mount Taba 'Nchu—the site of the Bloemfontein water-supply—is in the hands of the enemy. While the tents are being tidied and the patients are eating their breakfast, the officers are called to tea and dry bread in the mess-shanty (a sail-cloth spread over poles), and the two juniors ride into town for the milk and butter for breakfast. Breakfast at 8 and dinner at 7.30 are the two meat meals of the

[* Mr. Stamford was transferred to the I.Y. Hospital.—Ed.]

day, porridge, bread and butter, and coffee completing the first; vegetables, bread, butter, and rum the second. Luncheon at 1.0 is a bread and cheese affair, and tea at four may include bread and jam. At 9.0 the medical officers start work. The sick from the regiments of the brigade, sent up by their regimental doctors, are seen by the major in command, and are either treated by him, "detained" for 24 hours, or at once admitted. The second in command rides into town to one of the so-called "pest-houses," an old school-house of not very good sanitary reputation, which has been filled with enteric cases—a case of coals to Newcastle. The third and fourth officers have so many tents apiece under their charge, some 50 or 60 patients each. The major in command looks after other tents, and one of the regimental officers comes up in the morning and is responsible for five more tents-full. The major in command here is senior medical officer of the Highland Brigade, and is held responsible for the work of the regimental officers, as well as the officers in the field hospital. Furthermore, whereas by theory there should be three field hospitals in every division, in this, as in most, there are as a fact only two field hospitals, one for each brigade, and the care of the divisional troops—artillery, cavalry, and so forth—is also thrown upon the brigade hospitals.

The medical officer in his rounds is accompanied by the two orderlies working in the tents under him. The writer of these notes has the care of one row of five ordinary bell-tents, officered by two orderlies and a ward master, and one marquee officered by two more orderlies under another ward-master. The bell-tents, twelve feet in diameter, which are designed to hold twelve healthy men on active service, lying like spokes of a wheel with their feet to the tent-pole, have now to hold as many as eight or nine sick men, although the worst cases, if not in marquees, are lying only three or four in a tent. The marquees, some twenty-four feet by fifteen, hold from twenty to five and twenty patients. When these are only moderately ill—and it must be remembered that practically any man unfit for full duty with his regiment or unit is sent to hospital—most of the men are sitting on their rolled-up blankets during the day-time, if not sitting or lying on the ground outside, and so there is abundance of room. But when six or seven men are lying down in a bell-tent, careful examination is very difficult. A second difficulty arises in the absence of thermometers and of sundry drugs—Salicylate, Bismuth, Digitalis, Dover's Powder, Glycerine, Ointments, and so forth—pending the arrival of the stores for which requisition has been sent in long ago. It is excellent training, however, for the medical officers who thereby learns the significance of pulse and respiration and the use of various drugs on which he has not been accustomed to rely, but may quite well do so. The alkaline treatment of acute rheumatism, and the fundamental importance of rest and dieting in diseases of the alimentary tract are instances in point. A third difficulty in treatment consists of the fact that, with the exception of twelve stretchers, the only bed available even for cases of enteric fever is mother earth, covered by a waterproof sheet and a blanket. Yet another difficulty may be mentioned, that arising from the paucity of bed-pans and the inherent prejudice of all men, especially of soldiers on active service, to their use. Pending the arrival of further stores, we have at present only three pans in the hospital for the use of 250 men, one-third of whom, it may be said, would in a civil hospital be confined absolutely to bed. As a consequence all the cases of diarrhœa or catarrhal dysentery, and all mild cases of enteric fever have to walk to the latrines at the end of the lines. It must be added that no obvious harm has occurred as yet to any patient.

The patient's names are written out in order in each medical officer's order-book; and opposite the name he writes his orders for the day, the man's diet, extras, drugs, and other treatment, together with any note as to pulse or other sign which he may care to add for his own future guidance. But it is of course difficult to find the back-entries of any particular patient. The diagnosis of each case is required as soon as possible, and must conform to the nomenclature drawn up by a committee of the College of Physicians. N. Y. D. (not yet diagnosed) is a saving clause. So is "headache," so also "diarrhœa," "simple continued fever," and the like.

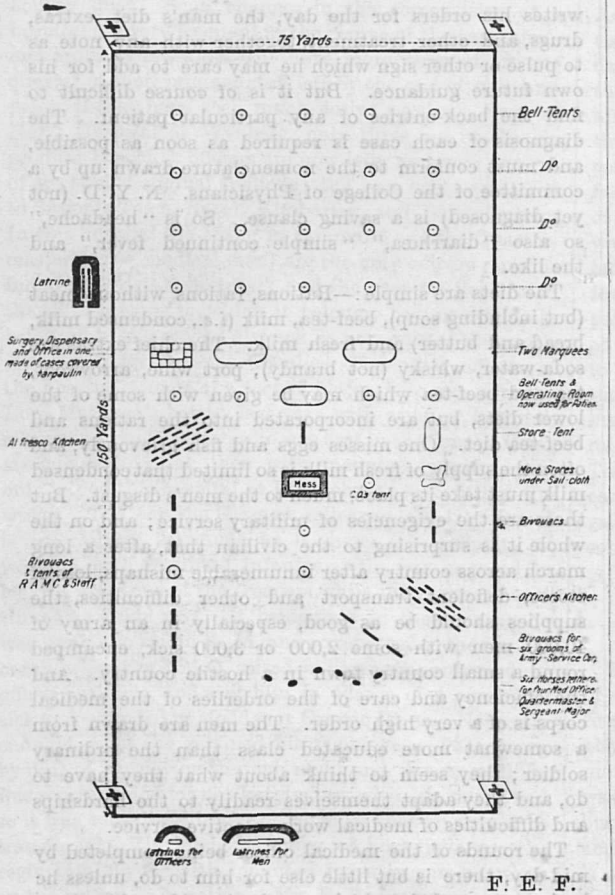
The diets are simple:—Rations, rations without meat (but including soup), beef-tea, milk (*i.e.*, condensed milk, bread and butter) and fresh milk. The chief extras are soda-water, whisky (not brandy), port wine, arrowroot, tea and beef-tea which may be given with some of the lower diets, but are incorporated into the rations and beef-tea diet. One misses eggs and fish grievously, and often the supply of fresh milk is so limited that condensed milk must take its place, much to the men's disgust. But these are the exigencies of military service; and on the whole it is surprising to the civilian that, after a long march across country after innumerable mishaps, loss of stores, deficient transport and other difficulties, the supplies should be as good, especially in an army of 40,000 men with some 2,000 or 3,000 sick, encamped round a small country town in a hostile country. And the efficiency and care of the orderlies of the medical corps is of a very high order. The men are drawn from a somewhat more educated class than the ordinary soldier; they seem to think about what they have to do, and they adapt themselves readily to the hardships and difficulties of medical work on active service.

The rounds of the medical officer being completed by mid-day, there is but little else for him to do, unless he be in command, in which case he is seldom free from documents and office-work all day. The junior officers take it in turn to remain in for 24 hours on end as orderly medical officer, and be ready for emergencies; and an evening visit is due either before or after dinner. Otherwise he spends his morning in smoking and chatting. He perhaps takes a ride or walks into the town, or to one of the officers' messes to see a friend in

the afternoon, and after dinner and a pipe retires to rest in his Wolseley valise.

The overcrowding of the field-hospitals is now being remedied by making this place an advanced base on a considerable scale. Nos. 8, 9 and 10 General Hospitals, the Portland, Langman and Iveagh (Irish), and No. 5 Stationary Hospitals are all either ready, or in process of being made ready, and on our advance they will, it is to be hoped, be fully prepared to receive all the sick which must necessarily be left behind by the Field Hospitals. In addition, two ambulance trains, and occasionally an ordinary train, leave here every week to convey sick patients to Naauwpoort or to Norval's Pont, where it is said the erection of a general hospital is proposed.

The following plan of this hospital will speak for itself:—



F. E. F.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

A Picnic at Magersfontein.

THE battle-fields of South Africa will form very popular holiday resorts as soon as the war begins to draw to a close, and the Modder Camp will be found a very convenient centre from which to visit Kimberley, Magersfontein, Enslin, Grasspan, and Belmont, all of which lie within a fifty mile journey by rail.

Every visitor will wish to go to Magersfontein, which is associated with the tragic fate of the Highland Brigade, and many of your readers may like to know what may be seen there at the present time.

I left the hotel at 7 a.m. in a two-horse cart intending to avoid the heat of the afternoon. The horses were poor starved creatures, but there was no choice, so I gave them a feed and took a bundle of fodder with me. The driver was a local Dutchman and not quite popular. To supplement his food I took a loaf of bread and tins of ham and salmon. For drink we had a bottle containing a mixture that was one-third whisky and two-thirds mystery, and half-a-dozen of soda water.

Following the road to the right along the Modder river, we saw the ground on which the battle of the Modder was fought. The Boers were concealed in the banks of the river and the British had to drive them out. At first the Boers held the south bank, but eventually our men forded the river near the bridge where it is shallow, and the Boers then had to retire to the north bank where there is still plenty of barbed wire to be seen as neatly pegged down as the string that protects the crocuses in Regent's Park.

After a drive of six miles you come to the commencement of the trenches, which start from the river bank and run a distance of about seven miles, where they almost reach the railway. One should walk along the trenches allowing the cart to follow at a short distance. The trenches are as new in appearance as if they had been made a week ago. The earth had been excavated for a depth of from two to four feet. A massive stone wall, several feet high, is built on the edge of the trench, and the excavated earth is neatly sloped in the form of an incline which reaches to the top of the stone wall, and this incline is concealed by cut bushes which are carefully laid on its surface. Even in broad daylight you do not notice the trenches till you are quite close to them. Behind the trenches are the Boer bush huts, which would be a discredit to a forest gipsy encampment. They cover about nine feet by six feet of the ground, and are formed of boughs that meet overhead. Some of them are supported on a light frame-work of sticks, whilst others are strengthened by a few yards of wire fencing secured with pegs. The huts are carpeted with the raw skins of sheep and oxen, which even now stink abominably.

I picked up a number of immense toasting-forks with which the Boers grill their food. Some of these forks have four prongs, and would hold several pounds of beef over the fire. There were also a number of three-legged iron pots in which the Boers stewed their food. I

gathered some wooden and metal spoons, a few skewers, a three-bladed lancet, some whip-handles in sections, and a Boer felt hat. There were bibles in English and Dutch and hymn-books too. There were English shrapnel cases near the river, but I could not take them on account of their weight, although they would have fetched a good price in Kimberley.

At 10 a.m. we outspanned, and I found that the Dutchman had absorbed half the whisky, so I put a very small reserve in a soda-water bottle for myself, and told the Jehu he could have the rest. It promptly disappeared. After breakfast I tried to sleep in a Boer bush hut spreading a stolen English tent on the ground as a carpet, but the bones and skins stank, and we again went forward.

Suddenly the trenches disappear and you might think the ground is free from them and that the road to Kimberley is open, but of course it is only a trap, with barbed wire near the trenches, and there are graves of many English near the spot.

Two miles ahead the copjes arise, and on one that is about 500 feet high the big Boer gun was placed. You climb up the emplacement and find it as fresh as if it were made yesterday. The big gun was in a depression ten feet deep with stone and sand-bags in front, and no amount of straight shooting from the plain on which the British guns were firing could hurt the Boer. But the English shooting had been very straight for the massive iron-stone rocks had been smashed all around the big gun by our lyddite. A dozen of our shells would have scored a bulls-eye off the big gun if it had not been below the surface.

I saw some nice large pieces of shell but no little bits, as excursionists on foot soon find large pieces inconvenient, and we passed no other cart that day. Three soldiers met us and sold the Dutchman a young springbock for five shillings. The soldiers had walked all the way and I gave them one of our two remaining bottles of "soda."

We now began the return journey; the heat was great, the horses were finished. The driver wanted to flog them but I made him get out and walk with me. He submitted to my abuse with a good grace, even when I told him that in London we should get three months hard labour as our reward. The Dutchman insisted that the horses were cunning, and that I had spoilt them by walking and making him walk. He was now very thirsty and his lips were black round the edges, for he had had a bad time and was rather inebriated the night before. The sand was deep, the sun was hot, and he licked the top of an empty soda water bottle trying to find one drop, but he never lost his temper for one moment. Once he said, "Boss, you are the best man I ever met," but he rather spoilt the effect by adding "Almaty, Almaty," as if he objected to walking. Two miles from home we had to stop, as we could not get home. I lay down under a bush, and although I did not feel very bright myself I would not let him touch that last soda. My eye fell upon a beautiful collection of empty mauser cartridge-cases, which were lying under the bush, and I knew that someone else had been compelled to leave his loot behind, although the Modder tents were only two miles off. When I was cooler I said to myself, "I'll have a few dozen of these cases, even if I carry them," and I pocketed a great many of them but not quite all.

When we had arrived a mile from home I shared the last 'soda' with the driver, and we had to leave the horses at a farmhouse before we reached camp. At the hotel they said the trip required four horses for even one passenger, and I am glad to remember that we suffered as much as our two poor beasts.

F. NEWLAND-PEDLEY.

Obituary.

Mr. J. A. Shaw Stewart.

By the death of Mr. Shaw Stewart of 48, Chester Square, and Dunrod, Torquay, the Hospital loses one of its oldest and most respected governors. For the long period of thirty-one years he has shown the greatest interest in the well-being of Guy's, and has taken a most active and intelligent share in its administration.

At the time of his election in 1869 he was, we believe, the treasurer of St. George's, in which office he is known to have displayed much aptitude and business capacity.

Born in 1829 to affluent circumstances, Mr. Shaw Stewart was educated at Eton and Christ Church, and on arriving at man's estate, soon took a prominent part in the religious and philanthropic work of the country. Numberless public and private charities owe a debt of gratitude to his discreet but generous liberality, and his old-world courtesy and high breeding could not fail to be noted by all with whom he came in contact. Known throughout the kingdom as a pronounced high-churchman, he allowed no bigotry nor intolerance to come near him; acting throughout life up to the high standard he professed, he permitted others to differ from him in all charity. His death has come as a shock to the Governors and Hospital Staff.

He formed one of the company on the 15th ultimo, at the annual dinner of the Governors and Staff at Limmer's Hotel, when he proposed in a vigorous and graceful speech the health of the Consulting Staff. The following day he became unwell, and soon sank.

The attendance at the funeral at St. Paul's, Knightsbridge, testified by its character and numbers to the esteem in which our late Governor was held by all classes of the community.

It must have been a painful ordeal for the Bishop of Rochester to read the burial office over his life-long friend, but to no one was it better known that it was the closing scene of a life well spent in the service of God and man.

H. W.

Vaccination.

THERE are many duties with which we can claim but a slight acquaintance on entering private practice, and frequently vaccination is of that class. It is one thing to watch an expert and another to do it by oneself perhaps many months later, and references to descriptions in books are often disappointing by reason of the omission of important details.

We may lay it down as a general principle that glycerinated vaccine as it leaves the vendor is always active, of suitable strength and free from impurities. Causes of failure should be looked for in the operator's methods, and until they are shown to be faultless no suspicion should fall on the lymph. The directions for use that are issued with many brands of lymph form a reliable basis for procedure. Firstly, users are generally implored to use the lymph soon after they have received it, but what do we often find in practice? That a man obtains a large tube of lymph, uses a little on a patient and seals up the tube again until the next baby is brought for vaccination. Small sixpenny tubes are now obtainable by return post, and patients can invariably wait until it arrives.

The choice of an instrument is an important point, and it is well for a man to decide on one and keep to it. The most usual forms are a needle, a lancet, or some special instrument issued by sellers of lymph; others scarify with the broken jagged end of a vaccine tube. Of these varieties, personally I hold the lancet in abhorrence. What is required is not so much a scarifier as something suitable for rubbing the lymph into the scratches, and the lancet is the worst of instruments for this function. Ordinary sewing-needles are very handy, are easily sterilized either by boiling or by passing through the flame of a spirit lamp and can then be wrapped up in a piece of lint needing no further sterilization, though perhaps used at a patient's house many miles off. The point is a very fair scarifier, and the eye end answers admirably for rubbing in the lymph.

I use two needles for each case, one to scarify, the other to rub in with, as the first must of necessity be held by the eye-end when scarifying, and with such an enemy as sepsis prevention is better than cure.

Pin-points, as issued by the Association for the Supply of Pure Vaccine Lymph, are longish needles with a flattened spear-like extremity, and having at the eye-end a little glass knob with a facet ground flat, to be used for rubbing in. They are sold ready sterilized at a penny each. The necessity for an elaborate outfit of portable sterilizers and what not must be indeed rare. It is easy enough to sterilize at home any quantity of needles and to carry them about safely all day if need be.

The skin of the child's arm should, of course, be washed with soap, rinsed, and rubbed dry. At this point, if not before, a discussion will arise between the mother and the doctor as to the number of "spots," and I would advise all men commencing practice to take a very firm stand on the subject. Let no amount of threats or coaxing allow you to go below at all events three satisfactory insertions. Many children in our large towns are the proud possessors of one "spot" only, and doubtless when they fall an easy prey to small-pox they will appear in the statistics as "vaccinated," to the delight of the heretics of Leicester. At present the law will accept the tiniest pustule as readily as it will three or four good marks.

We may always tell hesitating parents that one insertion, besides being valueless, causes the child almost as much irritation and discomfort as three or four places; the redness and swelling is not proportionate to the amount of vaccination. The best opinions seem to differ as to the proper depth of scratching; the limits are drawing blood on the one hand and merely scraping the epidermis on the other. The use of an ejector is much to be commended, as apart from actual desirability it looks much better than blowing the lymph out with the mouth.

Due rubbing of the lymph into the scratches is one of the prime factors of success. However widely and deeply you may scarify, or however much lymph you may use, it is of no avail if it be not well rubbed in. And conversely with good rubbing, only small areas of shallow scratches are needed to produce vesicles much larger than the original scarification.

Lastly, I would strongly recommend the use of wood wool pads. They cost about three halfpence each and are most satisfactory alike to patient, to mother and to doctor. They exclude dirt, they prevent the chafing of clothes and shield the scabs from being knocked off too soon.

The pricking of pustules at the end of a week is apparently a matter of opinion. I have never seen any bad results from leaving them alone, and the contrary certainly opens the door to septic infection.

Careful vaccination pays well from every point of view, but we cannot do too much towards proving to patients that properly performed it brings none of the plagues and terrors fathered on it by the anti-vaccinator. There is no doubt that we ought to be strict in only vaccinating healthy children, and, personally, I am reluctant to vaccinate babies under three months old. By that time the child often shows of what stuff it is made; eczema, syphilis, and marasmic conditions (none of which are confined to the poor) will very likely have shown themselves if the child is liable to them, and vaccination will not be reproached for being the cause. A prosperous practitioner told me that soon after commencing practice he made an appointment to vaccinate a baby, but forgot all about it for a week. Somewhat annoyed with himself he went to the house and found that the child had meanwhile blazed out in a mass of eczema. Had he kept the appointment the mother would have freely blamed the vaccination.

M. A. K.

Surgeon-General H. Skey Muir,

C.B., M.D., DEPUTY DIRECTOR-GENERAL ROYAL ARMY MEDICAL CORPS.

We are indebted to Mr. R. Clement Lucas for the following record of the distinguished services of a new Guy's C.B.

Surgeon-General Henry Skey Muir, M.D., whose name appeared in the Birthday *Gazette* as recipient of the C.B., was born in 1841 at Corfu (son of Dr. H. Muir, who was *Capo di Sanità* of the Ionian Islands, and a resident there for twenty-five years) and educated at Queen Elizabeth's School, Ipswich, and at the University of Glasgow, where he commenced the study of medicine in 1859, matriculating at the University of London in that year. Having passed two medical sessions at Glasgow he entered Guy's in 1861, and in 1863 graduated M.D. Glasgow, and took the M.R.C.S.E. While at Guy's he was in the cricket eleven captained by C. H. Smith, of Sussex.

He entered the Army Medical Department 31st March, 1864, and the following is a *resumé* of his services :—

1864–70—Staff Assistant Surgeon in Nova Scotia.

1870–71—Home, and gazetted Assistant Surgeon 6th Foot (Royal Warwicks).

1871–76—With his regiment until promoted Surg.-Major (1876).

1877–82—First tour of service in India. In the Punjab, and in the Afghan campaign; marching with the Kandahar column under Sir Donald Stewart (Medal—Action of Shahjui—mentioned in despatches).

1882–86—Home. "Trooping tours" to Barbadoes and afterwards to Cape Town, Durban, Bombay, Suez, and home.

1887–93—Second tour of Indian service. Promotion to Brigade-Surgeon (1888). In charge of Lucknow Station Hospital (1891–93).

1893–95—Home, and placed in charge of Cambridge Hospital at Aldershot, but promotion to Surg.-Colonel's rank occurred in December, 1893, and he became Principal Medical Officer of the N.W. District.

1895–96—At the end of 1895 the exigencies of the service compelled him to proceed to India again, and this time to the Madras Command as P.M.O. Secunderabad and Belgaum districts.

1897–99—In the latter appointment he remained only sixteen months when promotion to Surg.-Major-General (somewhat sooner than could have been anticipated, owing to a death vacancy) necessitated his transfer to Egypt in January, 1897. He remained in Egypt as P.M.O. two years, *i.e.*, during the progress of the Nile campaign of 1898. He did not accompany the Forces under Lord Kitchener, but he was responsible for the medical preparations and organization for the British Division which fought at Atbara and Khartoum, and his services were mentioned in the covering despatch of Sir Francis Grenfell, G.C.B., commanding in Egypt.

The appointment of Deputy Director-General at the War Office having become vacant in February, 1899, Surg.-General Muir was selected for it, thus ending his foreign service, which amounts to over twenty years.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Late Stanley Whicher.

DEAR SIR,—Old Guy's men will hear with much sorrow of the death of Stanley Whicher, which took place here on April 27th from enteric fever. He was attached soon after landing in Natal to No. 4 Stationary Hospital then at Frere. With it he moved to Springfield and Spearman's Camp, taking his share in the discomforts and hardships attendant on a hospital at the front, and applying his Guy's experience and training to the wounded at Spion Kop and Vaal Krantz. In the retreat which followed the latter fight, he and I parted, he to follow the chances of No. 4 Stationary Hospital to Chievely, while I returned to Mooi River with a convoy of wounded.

At Chievely the sanitary conditions were evidently trying. Out of the seven medical officers of the hospital three contracted enteric, and two are now dead of the disease. Whicher, who had been ailing with diarrhœa for some fourteen days, during which time with pluck and endurance he continued his duties, was sent down here with enteric fever on April 11th. From the first day of admission his condition was unsatisfactory. It seems as though his rough life in camp had enfeebled his combative power with disease. His temperature was never very high, nor was there any sign of deep ulceration, but frequent attacks of syncope and signs of cardiac weakness made us all anxious. In spite of every comfort and attention, champagne and injections of strychnia, he gradually became weaker and passed away on April 27th.

The following day he was buried with military honours in our cemetery here, and was followed to his grave by all the officers of No. 4 General Hospital, and many from the camps around. His last resting place is a quiet spot on the top zone of the neighbouring hills, well enclosed and tended, and we hope shortly to erect a permanent cross over his grave in memory of one whose loss we greatly deplore.

Too much cannot be said of the care and attention bestowed on our late chum by Major Hackett, R.A.M.C., under whose care he was during his illness at the Officers' Hospital here, and poor Whicher's friends may rest

assured that everything that could be done, even had he been at home, was done for him here.

STANLEY COPLEY.

No. 4, General Hospital,
Mooi River, Natal, S.A.,
May 4th, 1900.

Guy's Hospital Athletic Club Sports.

DEAR SIR,—As Secretaries of the Athletic Club we should like to call the attention of your readers to the fact that our Annual Athletic Sports will be held in less than a fortnight. Despite the proximity of the date the entries are very few indeed, and of those entered a large number are very unlikely starters. We had hoped that the low-water mark of athletics at this hospital had been reached last year, but the general outlook at the present shows that the tide has not yet turned. It rests with the men themselves to stay this degeneration in our sports, with the freshmen whose abilities can only be gauged in open competition, and with the senior men who may already have some reputation in other branches of athletics.

The difficulty of training can no longer be urged as an excuse. With the facilities now afforded for running at Honor Oak Park very little time would be lost, and certainly none wasted, by three or four practices a week.

To those, then, who would see our Sports rise above the level of a "garden party with donkey races," to those who have honest enthusiasm for the sport of running, we appeal for support, material and moral, and them we urge to help us score a success in every single detail.

The entry lists are still open, and names may be entered on the form in the smoking-room. However, it must not be forgotten that we want not merely additional entries but an increased number of real *starters*.—We are, Sir, yours sincerely,

D. H. TRAIL } Hon. Secs.
R. S. ROPER } G.H.A.C.

Notice.

THE following Appointments will become vacant in September next. Applications to fill the vacancies should be addressed to the Treasurer, Superintendent's Office, Guy's Hospital, S.E., on or before June 18th, 1900. Further particulars may be obtained from the Dean.

MEDICAL SCHOOL.

A Demonstrator of Anatomy.
A Demonstrator of Bacteriology and Sanitary Science.
A Demonstrator of Biology.
A Demonstrator of Microscopical Pathology.
Two Demonstrators of Physiology.
A Demonstrator of Psychology.
An Obstetric Registrar.
An Ophthalmic Registrar.

DENTAL SCHOOL.

Three Assistant Dental Surgeons.
A Lecturer on Dental Mechanics.
A Demonstrator of Dental Mechanics.
A Demonstrator of Dental Microscopy.
Four Dental Anæsthetists.
A Curator of the Dental Museum.
A Demonstrator of Practical Dentistry attending on Wednesday Afternoon*.
A Demonstrator of Practical Dentistry attending on Monday and Thursday Afternoons†.
A Demonstrator of Practical Dentistry attending on Tuesday and Friday Afternoons†.
A Demonstrator of Practical Dentistry attending on Monday, Wednesday and Friday Mornings‡.
A Demonstrator of Practical Dentistry attending on Tuesday, Thursday and Saturday Mornings‡.

* With charge of Extraction classes.
† With charge of Revision classes.
‡ With charge of Probationary classes.

Guy's Hospital,
June 6th, 1900.

Sport.

Cricket.

GUY'S v. HORNSEY.

This match was played at Honor Oak in bad weather, and resulted in an easy win for the Hospital. Hornsey, unfortunately, were two short.

GUY'S v. SURBITON.

This match was played at Surbiton on May 19th. The Hospital batted first, and lost 6 wickets for 82 before lunch, after lunch Morres and Brydone added 107 for the seventh wicket, and the last wicket put on 41. Surbiton were disposed of for 115 just before time. The Hospital thus won by 142 runs. Score:—

GUY'S.

G. S. Graham-Smith, c Taylor, b W. F. Forsyth	5
H. S. Barber, c Taylor, b Jupp	30
M. C. Wetherell, b Jupp	5
H. M. Langdale, b Addison	27
F. C. Wetherell, lbw, b Forsyth	1
J. M. Brydone, b Forsyth	36
R. C. Poyser, b Jupp	13
F. Morres, c Bevan, b Castle	57
E. A. Collins, b Forsyth	16
H. Edey, not out	17
C. M. L. Cowper, b Jupp	31
Extras	19
Total	257

SURBITON.

H. Davenport, b Edey	33
S. S. Taylor, lbw, b M. Wetherell	3
A. E. Newton, b Cowper	1
N. C. Cooper, b M. Wetherell	9
R. A. Bur, lbw, b Cowper	0
C. H. Jupp, b Edey	25
W. F. Forsyth, b F. Wetherell	2
P. Castle, b F. Wetherell	4
C. Scarf, b F. Wetherell	0
Rev. F. Beaven, c Graham-Smith, b Cowper	12
H. Addison, not out	11
Extras	15
Total	115

GUY'S v. BECKENHAM.

This match was played at Beckenham, on a soft wicket, and resulted in an easy win for the home side.

BECKENHAM.

J. Robertson Walker, c Edey, b M. Wetherell	0
A. A. Baker, c Graham-Smith, b M. Wetherell	0
W. M. Torrens, b Edey	47
P. C. Baker, b Trubshaw	13
F. D. Browne, c & b Morgan	36
J. K. Stenning, c & b Edey	2
C. O. Cooper, b Edey	6
J. G. Gulliver, c Cowper, b Edey	13
C. M. Baker, run out	29
J. H. Tod, b Morgan	1
J. E. Curwen, not out	0
Extras	19
Total	166

GUY'S.

H. Barber, c & b C. M. Baker	4
G. S. Graham-Smith, b C. M. Baker	7
K. V. Trubshaw, b C. M. Baker	0
M. C. Wetherell, c Stenning, b A. A. Baker	8
J. M. Brydone, run out	0
E. Morgan, c Cooper, b C. M. Baker	4
R. C. Poyser, not out	10
F. C. Wetherell, c Walker, b A. A. Baker	2
E. A. Collins, b A. A. Baker	0
T. H. Edey, b C. M. Baker	3
C. M. L. Cowper, b A. A. Baker	4
Extras	8
Total	48

2ND INNINGS.

K. V. Trubshaw, c Curwen, b P. C. Baker	36
J. M. Brydone, b Curwen	7
G. S. Graham-Smith, not out	48
H. Barber, not out	49
Extras	4
Total (2 wickets)	144

GUY'S v. ST. MARY'S.—HOSPITAL CUP TIE.

This match was played at Chiswick, on May 29th, and resulted in a win for our opponents by 118 runs. Guy's batted first, and on a good wicket only realised 116 runs. These our opponents knocked off for the loss of six wickets. Score:—

GUY'S.

H. Barber, b Mitchell	2
F. C. Wetherell, b Sedgwick	16
G. S. Graham Smith, run out	1
K. V. Trubshaw, run out	0
M. C. Wetherell, c Hobbs, b Causton	21
H. M. Langdale, b Gouiese	14
F. Morres, c Gouise, b Causton	27
J. M. Brydone, c Cheatle, b Sedgwick	5
R. C. Poyser, b Sedgwick	13
T. H. Edey, not out	0
C. M. L. Cowper, c Sedgwick, b Causton	7
Extras	10
Total	116

ST. MARY'S.

F. C. Hobbs, b Edey	11
W. G. Cheatle, b F. Wetherell	33
G. B. Norman, c Graham Smith, b Edey	14
C. P. Causton, c Graham Smith, b Edey	0
R. R. Gouise, b Cowper	39
S. L. Carey, b Cowper	6
W. Finlayson, b Poyser	31
A. V. Sedgwick, b Trubshaw	29
A. S. Mitchell, b Poyser	33
J. H. Collerhard, c Cowper, b Poyser	0
F. Nicholson, not out	30
Extras	8
Total	234

GUY'S 2ND XI. v. ST. THOMAS'S 2ND XI.

Played at Chiswick on Wednesday, May 16th.

Won easily by 104 runs. Barber played brilliant cricket for 79, and Bowle captured four of the St. Thomas's wickets for 16 runs. Scores:—

GUY'S.

H. Barber, b Wootton	79
F. Morres, c McCloughan, b Devas	1
S. C. Bowle, b Fielding	0
H. Langdale, c Simpson, b Devas	20
T. Morgan, b Wootton	12
E. A. Collins, b Thompson	28
A. M. Tollhurst, lbw, b Wootton	2
T. A. Chignell, c Fielding, b Wootton	1
W. H. Bush, not out	7
R. D. Bridger, b Devas	0
G. Carlisle, b Devas	0
Extras	10
Total	160

ST. THOMAS'S.

R. McCloughan, b Bowle	1
H. T. Simpson, c Barter, b Bowle	2
H. C. Devas, b Morres	0
T. C. Wootton, c Collins, b Morres	1
S. Fielding, b Bowle	23
R. F. Thompson, not out	10
B. Bathurst, c Chignell, b Morres	5
H. Read, c Barber, b Bowle	5
T. Penn, b Carlisle	1
K. Sahaki, b Carlisle	0
Extras	8
Total	56

GUY'S 2ND XI. v. THORNTON HEATH.

(DRAWN).

Played at Honor Oak Park, Saturday, May 19th.

GUY'S.

S. C. Bowle, c Barnes, b Swain	2
P. H. Turner, c Marchant, b Barnes	37
R. C. Mullins, b Swain	7
T. P. Thomas, b Swain	5
E. W. Strange, b Swain	13
W. H. Bush, b Barnes	4
T. A. Chignell, b Barnes	0
B. Glendinning, b Swain	25
R. D. Bridger, run out	2
F. C. Robinson, not out	16
G. Carlisle, did not bat	
Extras	16
Total for 9 wickets	*127

*Innings declared closed.

THORNTON HEATH.

F. Mackenzie, c Bush, b Carlisle	2
A. C. Jones, lbw, b Carlisle	28
W. Trent, run out	30
J. C. Foreman, b Bowle	28
H. E. Barnes, not out	17
Marchant, not out	6
Extras	8
Total for 4 wickets	119

GUY'S 2ND XI. v. DULWICH.

(DRAWN).

Played at Honor Oak Park on Saturday, May 26th.

DULWICH.

G. Proctor, b Bowle	9
W. Frizell, c Strange, b Bowle	14
H. G. Crier, c Bush, b Carlisle	51
H. Fishwick, b Chignell	18
S. Colyer, run out	11
S. E. Huntley, not out	31
F. G. Finlinson, c Chignell, b Bowle	4
F. E. Stafford, b Bowle	4
F. Twigg, b Bowle	9
—. Cowan, c Carlisle, b Peall	5
Extras	18
Total	174

GUY'S.

P. H. Turner, c & b Fishwick	3
T. P. Thomas, b Stafford	0
A. M. Tollhurst, not out	52
R. D. Bridger, b Stafford	0
S. C. Bowle, c & b Stafford	55
E. W. Strange, b Proctor	4
F. C. Robinson, b Proctor	12
G. Carlisle, not out	4
Extras	6
Total	136

W. H. Bush, T. A. Chignell and P. A. Peall did not bat.

GUY'S 2ND XI. v. ST. THOMAS'S 2ND XI.

(DRAWN).

Played at Honor Oak Park, Saturday, June 2nd.

Bowle, Morgan and Thomas batted well for Guy's, the latter's 47 containing a 6, a 5, and five 4's. Morgan took five wickets for 27 runs. Score:—

GUY'S.

A. M. Tollhurst, c Downes, b Mills	5
W. H. Bush, c Mills, b Downes	29
E. Morgan, lbw, b Downes	43
R. C. Mullins, c Patch, b Downes	5
S. C. Bowle, b Downes	44
F. C. Robinson, c Holland, b Downes	10
D. Steele-Perkins, c & b, Downes	0
T. P. Thomas, not out	47
R. D. Bridger, b Mills	10
G. Carlisle, b Mills	8
T. Gardiner, b Mills	5
Extras	21
Total	227

ST. THOMAS'S.

R. F. Thompson, b Morgan	24
— Downes, b Bowle	0
J. C. Wootton, c Steele-Perkins, b Morgan	13
H. Wheelwright, b Morgan	0
B. M. Dunston, c Bridger, b Morgan	1
G. T. Holland, b Morgan	4
H. S. Sington, b Carlisle	1
L. Bathurst, not out	3
H. A. Triddle, not out	9
Extras	13
Total	68

B. Patch and C. Mills did not bat.

HOS.-SCHO. C.C. v. ST. BARTHOLOMEW'S HOSPITAL STAFF.

(WON BY 106 RUNS).

Played at Brockley, June 2nd, 1900. Hos.-Scho., 120 for 5 wickets (declared); Bart's., 14. For Guy's Staff: Causby made 56 runs, and Lyons 32 runs; both not out; Arnold took 4 wickets for 6 runs, and Bailey 6 wickets for 3 runs.

HOS.-SCHO. C.C. v. GREAT NORTHERN HOSPITAL STAFF.

(WON BY 58 RUNS).

Played at Brockley, June 4th, 1900. Hos.-Scho., 103; Great Northern Hospital, 45. For Guy's Staff: Bailey 36, Causby 18, and Hussey 10; Arnold took 3 wickets for 12 runs, and Hussey 4 for 4 runs.

Guy's Hospital Lawn Tennis Club.

GUY'S v. HAROLD.

This, our first home match, was played on Saturday, May 26th, and resulted in a win for the Hospital by 7 matches to 2, 16 sets to 6, or 120 games to 85. This was not satisfactory as the opposing team was weak, but a glance at the score of the third couple will show that two matches were just lost after three sets, for they won one match out of three, but the sets were four all, and of games, they won 40 and lost 39.

Of the first two couples, the results so far this season show that the first get very slightly better results, but we were surprised to see how badly they broke up against our opponents' third couple; they could not keep any length on their drives, and were not able to "drop" the ball at all satisfactorily. This is attributable to want of practice. Score:—

H. K. Lacey and H. Bacon beat R. B. Ransford and Dr. Eccles, 6–2, 6–1; beat G. L. Bright and H. Penn, 6–3, 6–4; beat N. Elliot Smith and E. L. Bates, 2–6, 6–2, 6–3. E. N. Jupp and B. H. Wedd beat G. L. Bright and H. Penn, 6–1, 6–4; beat R. B. Ransford and Dr. Eccles, 6–3, 6–4; beat N. Elliot Smith and E. L. Bates, 6–3, 8–6. H. Wacher and L. Cooke lost to N. Elliott Smith and E. L. Bates, 6–8, 7–5, 1–6; beat G. L. Bright and H. Penn, 6–3, 6–4; lost to R. B. Ransford and Dr. Eccles, 6–0, 5–7, 3–6.

GUY'S v. KENT L. T. C.

Played at Honor Oak Park on Saturday, June 2nd, and resulted in a win for Kent L. T. C. by 8 matches to 1, 16 sets to 3, 108 games to 61. Score:—

E. N. Jupp and H. K. Lacey lost to Escombe and Hooks, 6–4, 1–6, 4–6; lost to Bristock and Galloway, 3–6, 2–6; beat Dunn and Simpson, 7–5, 6–1. J. D. Pye-Smith and B. H. Wedd lost to Bristock and Galloway, 2–6, 2–6; lost to Dunn and Simpson, 2–6, 3–6; lost to Escombe and Hooke, 3–6, 1–6. L. Cooke and H. Bacon lost to Dunn and Simpson, 5–7, 3–6; lost to Escombe and Hooke, 3–6, 1–6; lost to Bristock and Galloway 3–6, 1–6.

GUY'S v. WEIGHTON.

At Honor Oak Park on Wednesday, June 7th, we beat Weighton easily. One of their couples failed to put in an appearance. We won by 8 matches to 1, 11 sets to 1, 71 games to 34. Score:—

H. K. Lacey and E. N. Jupp beat Hodgson and Barlow, w.o.; beat Condy and Cantley, 6–2, 6–2; beat Klein and Shortland, 6–1, 6–0. B. H. Wedd and H. Bacon beat Condy and Cantley, 6–4, 6–2; beat Klein and Shortland, 6–3, 6–4; beat Hodgson and Barlow, w.o. H. Wacher and L. Cooke beat Klein and Shortland, 6–3, 6–1; beat Hodgson and Barlow, w.o.; lost to Condy and Cantley, 6–0, 4–6, 1–6.

GUY'S 2ND VI. v. LONDON HOSPITAL 2ND VI.

This match was played at Honor Oak on Saturday, May 19th, and resulted in a defeat for us by 2 matches to 7. Our team was not at full strength, but it is to be hoped that we shall have better fortune in future. Winckworth was in good form and scored repeatedly with his service. Score:—

H. L. Winckworth and C. D. Pye-Smith lost 3–6, 6–3, 2–6; lost, 4–6, 3–6; won, 7–5, 7–5. W. L. M. Day and L. G. Nash lost, 4–6, 1–6; lost, 10–12, 4–6; won, 6–4, 6–2. H. Davies-Colley and W. C. Lewis lost, 2–6, 0–6; lost, 0–6, 2–6; lost, 2–6, 0–6.

The date of the Cup Ties has been finally settled for Wednesday, Thursday and Friday, June 13th, 14th and 15th, provided Chiswick Park are able to lend the ground on those days.

The draw is as follows:—

St. Thomas's, bye.
St. George's }
St. Mary's }
St. Bart.'s }
London }
Guy's, bye.

United Hospitals' Swimming Club.

A meeting of the United Hospitals' Swimming Club was held at St. Bartholomew's Hospital on Thursday, May 10th, 1900, at 4·30 p.m. Representatives from St. Bartholomew's, St. Mary's, Guy's and Westminster Hospital Swimming Clubs were present.

The minutes of the last meeting having been read and confirmed, A. H. Blaxsome (St. Bart.'s), being in the chair, the report and balance sheet of the past year were read, and after some remarks from the Secretary, passed.

With regard to the United Hospitals' team racing cup, it was resolved that the different hospitals be asked to subscribe to pay off the balance of £1 19s. 6d. due upon the cup to Messrs. Elkington & Co.

The advisability of running an United Hospital Polo Team again this year was questioned on account of the number of members of last year's team at present at the war in South Africa. After much discussion it was decided to again run a team.

Fixtures were arranged with Oxford and Cambridge Universities.

The draw for the United Hospitals' Polo Cup was then proceeded with, and resulted as follows:—

ROUND I.—A. St. Bart.'s v. Charing Cross.

B. London v. St. George's.

Byes.—Middlesex, Westminster, Guy's, St. Thomas's and St. Mary's.

To be played off before June 6th.

ROUND II.—1. Winner of A v. Westminster.
2. Middlesex v. St. Mary's.
3. Guy's v. St. Thomas's.

Winner of B.—*Bye.*

Played before June 20th.

ROUND III.—Winner of B v. 1.
Winner of 2 v. 3.

Played before June 27th.

FINAL *on July 11th.*

Draw for the team racing :—

ROUND I.—A. St. George's v. Guy's.
B. St. Mary's v. Middlesex.
C. St. Bart.'s.
D. St. Thomas's.
E. London.
F. Westminster.
G. Charing Bross.

To be swum before June 6th.

ROUND II.—1. Charing Cross v. St. Bart.'s.
2. St. Thomas's v. A.
3. B. v. Westminster.
4. London—*Bye.*

Swum before June 20th.

ROUND III.—1 v. 4.
3 v. 2.

Swum before June 27th.

FINAL, July 11th.

W. H. G. THORNE,
Hon. Sec. U.H.S.C.

Guy's Hospital Swimming Club.

List of matches.

May	28.	Grafton	Southwark.
June	1.	Tadpole	Southwark.
„	5.	Old Coburg*	Southwark.
„	12.	St. Saviour's*	Southwark.
„	19.	Barry*	Southwark.
„	22.	Grafton	Forest Hill.
„	29.	City of Westminster	Southwark.
July	10.	Croydon Dolphin*	Croydon.
„	11.	Final Inter-Hospital Cup	Bath Club.
„	18.	Tadpole	St George's.

* Surrey County Junior Championship.

Guy's Hospital Football Clubs.

The Annual General Meeting of the Rugby and Association Football Clubs was held in the Anatomical Theatre on Thursday, May 17th, and was largely attended.

On taking the chair, Mr. Jacobson, in a few words, paid a fitting tribute to the memory of the late President, Mr. Davies-Colley, whom he characterised as a man of unexampled integrity of purpose, and devotion to duty.

The reports of the past season were read and adopted, and the following officers elected for the season 1900–1901 :—

President : W. H. A Jacobson, Esq.

RUGBY CLUB.—Captain : H. A. Cutler. Hon. Secretary : A. H. E. Wall. Committee : E. M. Harrison, A. O'Brien, R. C. Lawry, M. C. Wetherell and R. C. Mullins. Captain 2nd XV. : R. D. Bridger. Captain 3rd XV. : H. D. Smart. Captain 4th XV. : G. H. Sherris.

ASSOCIATION CLUB.—Captain : W. M. Robson. Hon. Secretary : H. P. Wiltshire. Committee . F. B. Manser, H. Barber, E. L. Norton, H. Bacon, T. A. Chignell. Captain 2nd XI. : P. A. Peale.

Guy's Hospitals' Rifle Association.

GUY'S v. DULWICH.

Wraysbury, May 9th, 1900, lost by 29 points.

	200 yards.	500 yards.	Total
Robinson, G. C. F.	4 4 3 5 3 3 5–27	4 4 4 2 5 5 3–27	54
Travers, O. B.	2 5 3 4 5 3 4–26	0 0 0 5 5 3 5–18	44
Hodson, J. E.	3 3 5 5 3 5 4–28	4 4 4 0 0 0 3–15	43
Hodgson, S.	4 4 2 2 2 2 4–20	2 3 2 2 5 4 4–22	42
Moss, B. W.	3 4 4 5 3 4 4–27	0 2 5 0 2 3 2–14	41
Keates	3 3 2 3 5 4 0–20	2 3 2 2 4 2 0–15	35
Lewin, G.	3 3 2 3 2 2 2–17	2 0 5 2 2 2 3–16	33
Oram, R. G.	3 2 2 2 3 3 2–17	0 0 4 2 2 5 3–16	33
	182	143	325

GUY'S v. R.I.E.C.

Cooper's Hill, May 19th, 1900, lost by 97 points.

	200 yards.	500 yards.	Total
Travers, O. B.	2 2 4 5 4 4 4–25	5 4 5 3 5 5 2–29	54
Oram, R. G.	5 4 4 2 5 5 5–30	0 4 5 4 2 3 2–20	50
Hodgson, S.	3 2 2 4 5 5 4–25	3 3 3 5 2 3 4–23	48
Felton	4 5 4 3 5 2 3–26	2 2 5 2 2 3 4–20	46
Hodson, J. E.	4 0 3 4 2 3 2–18	2 3 4 5 5 3 3–25	43
Glanville	4 4 4 3 2 0 2–19	2 0 2 3 3 3 2–15	34
Keates	4 2 3 0 3 4 2–18	4 0 2 0 2 0 0– 8	26
Webber	2 2 0 3 0 2 0– 9	0 0 2 2 0 0 0– 4	13
	170	144	314

Deaths.

LIDIARD.—On May 26th, at Springbank Road, Hither Green, S.E., Sydney Robert Lidiard, M.D., aged 48 years.

PEARSE.—On May 20th, at Brierley Hill, Edward Sainthill Pearse, M.R.C.S, L.R.C.P., formerly of Bradninch, Devon, aged 70 years.

STAMPER.—On May 22nd, at 13, Pembroke Street, Pembroke Dock, South Wales, James Fenton Stamper, M.D., J.P., aged 62.

ED.—S. H.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well a subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

June, 1900.

Sat. 23.—Messrs. Jacobson and Fripp's take-in; Drs., H. C. Keates and A. Wylie; Cl., C. R. Thomson.
G.H.C.C., I., Eastbourne, away.
II., Old Charlton, home.
G.H.L.T.C., I., Wanstead, away.
II., St. Thomas's, home.

Mon. 25.—1.15 p.m. Clinical lecture by Mr. Targett.

Wed. 27.—1.30 p.m. Clinical lecture by Dr. Hale White.
G.H.C.C., II., Blackheath School, away.

Thur. 28.—Messrs. Howse and Symond's take-in; Drs., F. Roberts and E. Roberts; Cl., P. W. Moss.
Second Conjoint Exam. begins.

Fri. 29.—G.H.S.C., City of Westminster S.C., home.

Sat. 30.—G.H.C.C., I., Reigate Priory, home.
II., Blackheath School, away.

July. G.H.L.T.C., I., Mr. Hall's VI., home.

Mon. 2.—1.15 p.m. Clinical lecture by Mr. Higgens.
August and October Appointment Lists opened.
First Part of the Conjoint D.P.H. Exam. begins.
Intermediate M.B. Lond. Exam. begins.

Tues. 3.—Applications to Medical School Office for Schedules for First Conjoint Exam. to be made out not later than this date.
Final Conjoint Exam. begins.

Wed. 4. Garden Party and Distribution of Prizes.
G.H.C.C., I., Gravesend, away.

July.

Thur. 5.—Messrs. Lucas and Lane's take-in; Drs., A. W. Soper and W. M. Robson; Cl., J. M. Brydone.
G.H.C.U., Address by H. H. Weir, Esq.

Sat. 7.—August Appointment List closed.
G.H.C.C., II., St. Bart.'s, away.
G.H.L.T.C., II., St. Bart.'s, home.

Guy's Hospital Gazette,

JUNE 23, 1900.

Some Complications of Typhoid Fever.

1. Cardiac Failure. 2. Rigors.

CLINICAL LECTURE BY DR. TAYLOR.

March 17th, 1900.

GENTLEMEN,—The complications of typhoid fever, which you can find alluded to and described in the larger works on the subject, are very many in number. But though there are many lesions which may occur in typhoid fever—and possibly, as one author has said, there is scarcely any fever that is followed by so many complications, excepting perhaps influenza—the general impression, which one has derived from observation in numerous cases of typhoid fever, is that a good many patients escape without these complications; that is to say, the percentage of cases of patients who have complications of any severity is a comparatively small one. When I say that, of course I do not allude to those numerous slight deviations from the natural course of the disease which may occur, such as a slight amount of albuminuria, a little bronchitis, or some congestion of the bases of the lungs, which are present in nearly all the more severe cases.

There are two cases to which I specially wish to refer on this occasion. The first is the case of a man, aged forty years. He was admitted on January 23rd, before I had charge of the ward, and he had what appeared to be a perfectly simple attack of typhoid fever. He came in apparently on the sixth day, and by the nineteenth day the temperature had reached normal. His temperature was never very high, rarely above 103°. On the third day after his admission, the blood gave a strong Widal's reaction, so that there appears to be evidence that he had typhoid fever. I need not go into

other points in reference to that. Clinically he had every characteristic of this fever. In the report of the case it is stated, on the 27th January, that the patient's bowels had been opened fairly regularly, and were typical of typhoid. The temperature became normal in the early part of February, and was normal when I took the case in hand (on February 15th) and continued normal until the 18th. On the evening of the 18th the temperature rose to 98·8°. On the 19th it was a little lower in the morning, and rose to 99·6° in the evening. On the 20th it was 97·2° in the morning, and rose to 102° in the evening, but had fallen on the following morning (the 21st) to 99°, and then rose to 104° in the evening. The report says on the 20th—the second day after a small rise of temperature—"The patient's temperature was up a little last night, and he seems very drowsy this morning. He only complains of his bowels not being properly opened. An enema was ordered at three o'clock." Two or three days previously he had had sufficient evacuation of his bowels —thrice on the 17th, twice on the 18th, once on the 19th. On the 21st his temperature went up to 104°, and his pulse was 120°. "The patient makes no complaint beyond not feeling quite so well. He is sweating a good deal. There is no distension or tenderness of the abdomen." Now, at that time, there was a certain resemblance to a relapse; it looked as if the temperature were rising as the first stage of such an event. The interval between this rise of temperature and the termination of his original typhoid fever was about fourteen days; and we know that an interval of ten or eleven days or two weeks is quite possible between the fever itself and the relapse. On the 22nd the temperature remained up between 102° and 103°. "The patient is still sweating profusely and is evidently very ill, though he does not complain. The heart-sounds have a somewhat triple character, and the impulse is outside the nipple line." There was no murmur. On the 23rd, "The cardiac impulse is about one inch outside the nipple line. Patient is very weak and is sweating a great deal. The pulse cannot be felt at the wrist. Patient says he has no pain. The specific gravity of the blood was taken and found to be 1051. There was a moderate increase of leucocytes which numbered 15,000 per cubic mm. Patient is rather cyanosed. The lungs are healthy." On the 24th, "The pulse can be felt this morning; it is 104, and is very small and feeble. The cardiac sounds are feeble and no bruit can be heard. The chest is normal in front. The lungs were not examined behind" — no doubt because the patient was extremely ill. "The patient complains of a slight pain in the upper part of the abdomen, but there is no distension or rigidity, and the abdomen moves well on respiration. This evening some resistance was encountered in the right hypogastric region, and a somewhat indefinite edge could be made out extending three inches below the costal margin. On percussion the abdomen was tympanitic over this area, and the stomach also gave a well-marked tympanitic note on the left side. The rest of the abdomen is resonant. The pulse cannot be felt. Patient's hands are very cold. He is in very good spirits, and does not complain of pain or distress. The breathing is rapid, and patient is rather cyanosed." Then on the 25th the report states, "On examination this morning the percussion note over the right hypogastric has altered. It is now dull, and the edge before felt appears to be that of the liver. The abdomen moves on respiration and is not distended. The pulse has improved. There is some hypostatic pneumonia of the right lung as evidenced by dulness and numerous râles. Musk was ordered 6.30 p.m. Patient became delirious and wanted to get out of bed. He soon quieted down and appeared to be sinking fast. His hands are quite cold and clammy." Then the patient became unconscious and died at 9 o'clock.

This case presents points of considerable interest. It appeared to be distinctly a case of typhoid fever. The patient had it comparatively mildly in the first instance, he seemed then to be convalescent, when he had a constantly developing, one might say, almost sudden rise of temperature. I remember my attention was specially called to him on Friday, February 23rd, three days after the temperature had begun to rise, and then he had an extremely feeble pulse, his hands were already cold, his face was pallid, with perhaps a little tendency to be cyanosed, and when examining the heart we found that the impulse was outside the nipple line, and the beat very feeble. The conclusion was, that here was a case of a patient whose heart was suddenly or rapidly giving way in consequence of typhoid poison, or the results of typhoid poison, and that the pulselessness and general coldness of the surface from which he suffered, were due to relatively rapid cardiac dilatation. We tried to modify that by giving digitalis and stimulants, and by injecting strychnine, but on the following

day the patient was not materially better. It was remarkable to see how little his sensorium, his mental condition, was affected by this failure of his circulation. It was curious to see him, whose condition we recognised as being extremely grave, criticising in a friendly way the severe illness of a patient in a bed opposite to him and remarking, "That poor fellow is very bad," or using similar words to these. And this curiously cheerful condition continued almost to the end of his life.

But the chief points of interest were that on carefully examining him on the 25th, when the temperature was falling, perhaps as a result of failing circulation, we found the positive enlargement or displacement of the liver and the dulness at the right base of the chest with the deficient entry of air and the existence of râles, which are mentioned in the report.

What was this condition of the lung? Two things were possible—one, that the patient had pneumonia, say, of the croupous type, not in this case giving bronchial breathing, for reasons which are not so infrequently present, because the tubes might have been blocked, but still giving râles and causing deficient air-entry; and then there was the possibility that he had hypostatic pneumonia, as it is called, that condition of congestion and partly œdema of the bases of the lungs which happens not infrequently in those extreme illnesses whereby the patient has to lie persistently on his back with a feeble circulation. An objection to this view was that the lesion was limited to the right side, or at any rate, it was very much more extensive on the right than on the left side.

Another suggestion presented itself, and that was that the dulness on the right side might be caused by effusion of fluid; and this was supported by the facts that the heart's impulse was displaced to the left and that the liver was encroaching upon the abdomen, and might be interpreted as being pushed downwards. If that had been the case, an exploration with a needle would have been the proper course, but he had not, even at that time, any very marked respiratory difficulties, and certainly early in the case difficulties of that nature were not prominent. I may say that when we saw the patient first, it was not thought that he was so seriously ill. When it was seen that the convalescence was interrupted, and that the temperature had risen again, it was the cardiac condition that was most prominent. The respiratory trouble did not seem to be at all a feature of importance. Then we may note that there was no dulness in front of the chest, and it was obvious that if any pleuritic effusion was present, it was insufficient to compress the anterior part of the lung.

You may get effusion on the right side of the chest, by which, it is true, the heart's impulse may be displaced somewhat to the left, but it is rarely that you get a displacement of the heart to anything like the extent that we had here, in a case of effusion which only shows or reveals itself by dulness at the right lung behind, and does not show itself by any dulness in front. Similarly the lower edge of the liver was much lower down than would be explained by a pleural effusion, if that effusion was in such small amount as the percussion of the chest indicated. If there was effusion, it was clearly not extensive effusion.

But when you have got your mind on the question of effusion, there are two or three possibilities. The patient might have a simple serous effusion. It is not very common in typhoid fever, and a diagnosis of pleuritic effusion should be made with some caution in association with that disease.

There was another possibility which occurred to me, though again there was really no visible evidence in favour of it, but still it was worth considering. The possibility that the patient might be suffering from an empyema on the right side, which might have arisen in consequence of an intestinal ulcer causing a localised peritonitis extending up towards the liver, and later on leading by perforation of the diaphragm to an empyema. It must be a very rare event, and it was not very likely in this case; the very rapid development of the symptoms, and the clinical symptoms and general conditions were decidedly against it. It was not likely that the patient should have such a lesion as that when he had gone for a whole fortnight without any high temperature, and was apparently in a perfectly progressive and satisfactory condition of convalescence.

There is another point of interest in this case with regard to our position at this stage of affairs. Going back into the original history of the patient's illness, that is, when he came in with the original typhoid fever, we find in the history that the heart and the liver were not quite normal. The heart's impulse is reported as being visible in the nipple line, and the area of dulness as being slightly larger than normal. The report also states that on the patient's admission the liver reached below the costal margin, though not so low as it was on the last day of the patient's illness.

Now comes in a further complication, namely, that of his occupation. He is a barman. His hours of work are long, and he drinks a moderate amount of liquor. It is obviously possible that the congestion of his liver, and even the condition of his heart, are more or less referable to his occupation and the unfair use he might have made of its waste products.

Having made that suggestion, let us see how far it or my remarks are borne out by the post-mortem results. The lungs showed thin adhesions between the upper and lower lobes, and a few between the middle and lower lobes. Both bases were in a soft condition from hypostatic pneumonia, and the right lung was a great deal more affected than the left. There were hæmorrhages under the pericardium. The mitral valve was four and three-quarter inches in circumference, and the tricuspid valve five inches. The organ was relaxed and fatty. The spleen was soft, but not very large, the kidneys normal, the liver nutmeg. No ulcers, fresh or healed, were found in the intestines, and no cultivations of Eberth's bacillus could be obtained from the spleen.

What, then, have we got? The heart was relaxed, was fatty, and actually dilated; there were hæmorrhages, and the pericardium generally suggested a septic condition. Then there was enlargement of the liver which was due not to cirrhosis, but to a nutmeg condition, that is, a congested condition. That must have resulted, I think, from some defect in the working of the heart. Then the patient had a condition not of croupous pneumonia, nor of effusion, nor of empyema, but one of hypostatic pneumonia. Therefore, so far as his fatal condition was concerned, we are thrown back, I think, upon what was originally suggested when he first became seriously ill, namely, that the heart failed. What was the cause of this heart-failure must be, of course, a matter of doubt. The heart-failure must, I suppose, be allowed to have existed from the first. When he first came in his heart was a little out of its normal position in one direction, and the liver was enlarged, and it is quite possible that the suggestion which I have already made in regard to the man's occupation may be a correct one. We know, for instance, that an unfair use of alcohol does lead sometimes to dilatation of the heart. There are cases described as alcoholic heart; an expression which involves the belief that an excessive use of alcohol leads to dilatation and imperfect action of the heart, which failing action of the heart may bring about all the results of valvular disease, namely, irregular action, a dilatation more or less, and subsequently congestion of various organs, the liver, kidneys, and so forth. Therefore, it is possible that the patient in this case, having suffered to a certain extent from a feebly-acting heart with defective circulation, in consequence of his occupation, was taken with typhoid fever which aggravated the condition of the heart and liver to an extent which resulted in a fatal termination.

The difficult point one has to determine is, how this could have been brought about in what appeared to be a condition of convalescence which had lasted fourteen days after the termination of his original fever. One way of explaining is by the suggestion that this fever we had coming on really was a relapse; it may have been a commencing relapse, and commencing rather severely, it may have acted prejudicially upon the heart and circulation, leading to increased dilatation of the heart, increased enlargement of the liver, and complicating the bases of the lungs in the way I have suggested.

Perhaps you may see another difficulty in the case, namely, that at the post-mortem no signs of ulceration of the intestines was found. What is the evidence, then, that this patient suffered from typhoid fever at all? Of course, the evidence chiefly in support of the view that he had typhoid fever, was the Widal reaction and the course of the illness. So I did not read you all about that; I took it for granted. Before we made our diagnosis all the points were fully considered. We found that the patient had rose-coloured spots on his abdomen, and that he had a course of temperature which entirely agreed with what we see in other cases of typhoid. The answer to the question, Why had he not any ulceration? is that ulceration is probably not necessary in every instance of an infection of Peyer's patches. Indeed, cases occur in which the Peyer's patches do not show ulceration, and if they do not show ulceration recovery may well take place after the subsidence of the swelling, and the patches may return to a perfectly normal condition. Moreover, in ordinary typhoid fever there must be many Peyer's patches which are simply swollen and infiltrated and inflamed and then the inflammation and swelling have subsided and the whole thing has recovered. Thus, there need be no ulceration whatever, and therefore no scar, so that I do not think that an entire absence of evidence from the intestine disproves the possibility of the case being one of typhoid fever, nor in any way the suggestions we have

thrown out in regard to the symptoms that agreed in the course of the disease and its fatal termination.

Well, now, as to the frequency of such complications. I am quite sure that this whole case as it stands is comparatively rare. Cardiac failure, rapid cardiac failure, may take place in a great number of these febrile illnesses. This patient reminded me of one such instance that occurred some years ago. The case was that of a gentleman about forty years of age. He had a severe form of typhoid fever and was taken rather rapidly with a condition of cardiac failure, combined with rather pronounced nervous symptoms. He became almost pulseless, the action of the heart being very feeble, and he was cyanosed and livid at the extremities of his body, the fingers, toes, ears, and the tip of his nose were quite blue and congested from venous stagnation. At the same time he was semi-conscious, delirious, refusing food, and trying to get out of bed from time to time. He had to be fed with a nasal tube in order to get food down at all. The condition persisted some days, but he recovered perfectly. I suppose he must have been in a condition not so very unlike the patient that we have before us. As you will have seen, we attempted to get the heart of our present patient to act by giving him digitalis and brandy, and subcutaneous injections of strychnine. We ordered him some musk at the last moment, but the patient got into a hopeless condition and died before that could be administered.

The next case we have in the wards, as bearing on the question of complications in typhoid fever, is one of a boy aged six and a half years, who came in with an illness which was sufficiently like typhoid fever to make us diagnose it as such, and this has been confirmed sufficiently by the ordinary evidence such as I mentioned before. He had numerous spots, he had a temperature which was running between 102° and 104° over a full fortnight, that is, from the 14th of February to the 2nd of March, and during that time it was rarely below 101°. The patient was dull and stupid, refusing treatment or food, and presenting all the characteristics of typhoid in a child at that age. On the 3rd of March, or the eighteenth day of his illness, in the early morning, or between ten o'clock on the 2nd and two o'clock on the morning of the 3rd of March, his temperature fell from 102·6° to 97°, and then it rose again in the morning rapidly to 104°.

Mr. A. H. Davies writes as follows in his clinical report: "Last night I saw the patient, who then had a good pulse, and slow, regular respiration. He was not sweating. At seven o'clock I again saw him, and his pulse was very weak; he also felt cold; he was still not sweating. Hot bottles were ordered, and a brandy injection. This did little good, and at half-past seven he was almost pulseless, his teeth chattering, and his respiration being rapid and feeble. His temperature, at a quarter-past seven, was 103·8°, respiration 36, pulse 156. Brandy was injected, and the patient soon afterwards became flushed, and the pulse rapidly improved, and the respiration quickened. During the night he had vomited three times, and was now vomiting again. His abdomen was not at all rigid, and not as distended as it was when the above note (March 1st) was made. The heart is normal. With regard to the lungs, there are signs of bronchitis. At about a quarter-past ten Dr. Shaw saw him and said that there was no fear of perforation, but he found no lesion to explain the condition.

You will see from the chart which I here produce that there were numerous rises of temperature during the week or so after that date. The temperature rose on the 3rd of March to nearly 104°, and he had a rigor with it. The temperature fell during the same day, so that at ten o'clock in the evening it was normal. After that it fell from 98·4° to 95·6°, so that in the early part of the 4th of March it was far below the normal. Then on the evening of the 4th it rose again to 105°, with a rigor, fell again to just below the normal, and rose again on the evening of the 5th to over 104°, with a rigor. It fell again in the course of the next twenty-four hours to below normal, rose again at ten o'clock on the morning of the 7th, with a rigor, to 105°. Subsequently it fell again and rose (a fifth time) on the evening of the 8th. On the 9th it fell to 95°, and remained so for nearly twenty-four hours. Then it rose again on the 10th at six in the evening to 104°, and it fell again on March 11th to 96° nearly, and from that time it has never risen above 98·6°.

To put the case briefly, on the seventeenth day of the child's illness the temperature suddenly fell below normal, and then from that time on, during the next nine days, he had these rapid elevations of temperature followed by somewhat less rapid falls. On three of these occasions the rise was accompanied by a rigor, the first, second, and fourth. Those rises of temperature were not uniformly determined by the time of the day; sometimes the rise was in the middle of the day, sometimes at the end, and sometimes at the beginning. They

were not actually daily occurrences; they were scattered over nine days. The last of those rises and falls was on the 11th of March, six days ago, and the temperature has been practically normal ever since, and we now see no reason why the patient should not get perfectly well.

Now, the question suggested itself, What was the cause of this decided disturbance of temperature with rigors? The phenomenon is rare, and I can only recollect a few cases of chills or rigors occurring in this way in the course of typhoid fever, though, doubtless, a search through one's case-books would yield some more. I remember the case of one of our house-physicians, several years ago, who had typhoid fever and recovered, and when he got to the third or fourth day of his convalescence he was seized with a rigor and his temperature rose to 105°. But in the course of another twenty-four hours it had all subsided, and he got perfectly well. I am not sure whether it was in his case or another that a second rigor took place under somewhat similar circumstances. With regard to our present case, I at first thought that it was a similar occurrence, that it was a rigor which probably would not be explained by any clinical conditions, and that it would get quite well, and the boy would recover. When other rigors occurred it looked as if there were something more serious behind it. The boy had been constipated, though not very seriously; for two or three days his bowels had not been opened when the fever first recurred. Before that he had his bowels opened once and sometimes twice a day. It was rather an aggravated condition of constipation, and we thought it possible that it might be the cause of the pyrexia. He had enemata and his bowels were opened, and still these rigors went on. Then, on the occasion of the fourth rise of temperature, we examined the patient carefully and found some bronchial breathing, with a few râles on the inner side of the scapula near the angle; it was not very extensive. I think one could not deny the fact that he had got some pneumonia. The following day this condition was not quite so marked, and it rapidly subsided and went on to normal. It is possible that this was the explanation of the condition which we had before us, but it is very unusual for pneumonia, except in pyæmia, to be accompanied by rigors of this kind.

Now, although rigors are so rare in typhoid fever, they have been dealt with in medical literature to a certain extent. I have here a pamphlet, which proceeds from the Johns Hopkins Hospital, and is by Dr. William Osler, and it has a chapter from the Reports of that hospital, entitled "Chills in Typhoid Fever." Dr. Osler's conclusions are as follows: He notes that chills occur sometimes in typhoid fever at the onset. Now, of course, we know that that is not common. The cases referred to in his pamphlet appear to be taken from a total of 229 cases; at any rate that is the total which he gives in some of the papers that accompanied this one. Well, the number of thirteen which he gives, in which he found chills at the onset, is a very small one and confirms our ordinary experience, that chills do not commonly occur at the commencement of typhoid fever. He had two cases in which the onset of a relapse was accompanied by a chill. Then there were three cases in which a chill occurred as a result of the treatment. We know that in the days when we used the various antipyretics, antipyrin and antifebrin in typhoid fever to reduce the temperature, chills would sometimes take place. In one of Dr. Osler's cases a hypodermic injection of sterilized culture of typhoid bacilli produced a chill: and chills also followed the application of guaiacol to the skin on two occasions. Then there were two cases in which a chill occurred with the onset of thrombosis, and he remarks what we should all suppose is possible, that with the onset of some inflammatory complications of typhoid fever, you may get a chill. Then he had two cases in which he supposed the rigors were due to some septic cause. There was a rise of temperature, and the temperature subsided, and the patients got well. These are similar unexplained cases to that of our former house-physician years ago, of which I told you; and were perhaps, what I was prepared to expect, the sort of thing that was happening in our present case before we found more definite lesions. Dr. Osler had other cases where chills have occurred and in which malaria, not an uncommon affection in Baltimore, where the hospital is situated, occurred concurrently with typhoid fever.

Well, then, perhaps some of you may be aware of this very interesting paper in the last volume of the Guy's Hospital Reports, published last year, a paper written by Dr. Brice Poole, who was recently house-physician here, and had charge of some cases in the epidemic of typhoid fever that took place at Maidstone during the last four months of 1897. He records some 210 cases that came under his particular notice, and he gives a very valuable analysis indeed of all the conditions that occurred in these various typhoid cases. He had chills in eight out of 210 cases; you see

that is infrequent. In three of these cases there was thrombosis of the femoral vein. In one case two rigors occurred on the eighteenth day of the illness, and were attributed to mental shock. I do not know what the mental shock was caused by, but it was attributed to something that the patient heard in connection with the loss of a relative in the course of the fever. In another case rigors occurred on the fourteenth and seventeenth days of the illness, and it was a little doubtful whether the chills were due to the drug administered or to constipation. Several rigors in another case were attributed to constipation. There were five rigors in one case of relapse, some of which appear to have been due to phenacetin; and in this case there was no constipation. In the remaining case, in which a rigor occurred on the tenth day, constipation was present. Of Dr. Poole's cases, therefore, three were due to definite complication, and the others might have been due to constipation, or the administration of drugs.

I think the probability is that the rigor in our case was due to a complication, namely, that of pneumonia; the only difficulty with regard to that view being, that the complication is one which we frequently see in other circumstances, and which does not generally produce such an arrangement of temperature and such a course of rigors as we had in the present case.

These cases of complication in typhoid fever are very interesting, and if you bear in mind the relation of chills in general you will not be unnecessarily alarmed at their occurrence in the course of this disease. You will try to find out what complication is possibly causing the rigor, and then endeavour to get rid of the cause. If the chill has no apparent cause, then you may rest assured of the fact that other cases have occurred in which chills have happened and not been satisfactorily explained, and in which, nevertheless, the patients have got perfectly well.

Notice.

DENTAL PRIZES.

THE PRACTICAL DENTISTRY PRIZE.—Messrs. A. H. Clogg, G. H. Morris, equal, £5 each.

THE FIRST YEAR'S STUDENTS' PRIZE.—Mr. G. H. Morris, £10, Mr. S. W. Iles, a Certificate.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

CASES UNDER DR. TAYLOR.

MARY
38. Multiple tubercular serous effusions.
39. Phthisis. Tubercular laryngitis.
41. Myelitis. Paraplegia.
43. Hemiplegia. Hemianæsthesia.
44. ? Malignant growth of liver.
45. Arsenical neuritis.
47. Aortic stenosis and regurgitation.
49. Post diphtheritic neuritis.
50. Hemiplegia. Hemianæsthesia.

PHILIP
23. Pleuro-pneumonia.
25. Ankylosed hip-joints from osteo-arthritis.
26. Phthisis.
27. Phthisis. Tubercular peritonitis.
28. Phthisis. Pneumo-thorax.
30. Mitral stenosis and regurgitation.
31. Locomotor ataxy. Primary optic atrophy.
34. Chronic interstitial nephritis. Albuminuric retinitis.
35. Pernicious anæmia.

CASES UNDER DR. HALE WHITE.

MARY
15. Exophthalmic goître.
18. Dilated stomach.
19. Acute rheumatism.
20. Hemiplegia.
21. Mitral stenosis.
23. Empyema.
24. Double mitral disease. Double pleural effusion.

PHILIP
2. Mitral stenosis and regurgitation.
3. Cerebral hæmorrhage with softening.
4. Diabetes.
5. Pericarditis.
6. Sarcoma of mediastinal glands. Pleural effusion.
7. Right hemiplegia.
8. Phthisis.
10. Ascites. Bronchitis. Albuminuria.
13. Mitral stenosis. Tricuspid regurgitation
14. Meningitis.
17. Apical pneumonia. General bronchitis.
18. Mediastinal growths.

CASES UNDER DR. PITT.

MARY
25. Acute Bright.
26. Purpura.
27. Diabetes insipidus.
28. ? Cerebral abscess.
29. Growth of colon.
30. ? Angina pectoris.

MARY	31.	Hysterical dilatation of stomach.
	32.	Renal calculus.
	33.	Pleuritic effusion.
	34.	Carcinoma of pylorus.
	36.	Pleuritic effusion and ascites.
	37.	Dyspepsia.
	Cot.	Marasmus.
STEPHEN	21.	? Insular sclerosis.
	22.	Pleuritic effusion.
	23.	Pleuritic effusion.
	24.	Empyema.
	25.	Lardaceous disease.
	26.	Pneumonia.
	28.	Enteric.
	30.	Aortic disease. Plumbism. Gout.
	31.	Chorea. Mitral incompetence.
	32.	Renal calculus.
	33.	Carcinoma of kidney.
	34.	Diabetes mellitus.
	36.	Pneumonia.
	37.	Enteric.
	38.	Chronic nephritis.
	39.	Carcinoma of stomach.
	40.	Carcinoma of liver.
	Cot.	Infantile hemiplegia.

CASES UNDER DR. PERRY.

MARY	1.	Ulcerative colitis ?
	4.	Pericarditis.
	5.	Empyema.
	6.	Eczema.
	7.	Typhoid. Pneumonia.
	11.	Myelitis.
	12.	Cerebral tumour. Crossed paralysis.
	52.	Broncho-pneumonia.
STEPHEN	4.	Epilepsy.
	5.	Hypertrophic cirrhosis. Ascites.
	6.	Pneumonia. Pericarditis. Empyema.
	7.	Granular kidney.
	9.	Growth cardiac end of stomach.
	10.	Tubercular peritonitis.
	14.	Chorea.
	16.	Mitral stenosis and regurgitation.
	18.	Acute rheumatism. Chorea.
	19.	Left pleural effusion.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

ASTLEY-COOPER	4.	Cut throat.
	7.	Supracondyloid fracture of femur.
	30.	Fractured patella.
JOB	6.	Vesical calculus. Recto-vesical fistula.
	9.	Old tubercular arthritis of hip.
	20.	Median paralysis following foreign body in arm.
	24.	Gumma of sternum. Surgical emphysema.
LYDIA	8.	Varicose veins and ulcer.
	16.	Tuberculous tarsus. Amputation.
	16.	Cleft palate and hare-lip.

CASES UNDER MR. LUCAS.

ASTLEY-COOPER	8.	Bullet in knee (non-perforating). Extraction.
	10.	Bullet in hand (non-perforating). Extraction.
	14.	Concussion with aural hæmorrhage.
	18.	Bilateral fracture of os calcis.
LAZARUS	5.	Recurrent epitheliomatous glands.
	3.	Recurrent epithelioma of glands.
	15.	Bilateral lipomata of arms.
	18.	Myeloid sarcoma of tibia.
	22.	Tuberculous periostitis of femur.
MARTHA.	9.	Old Pirogoff's amputation. Painful stump.
	21.	Tuberculous arthritis of knee.
	Cot B.	Congenital inguinal hernia.

CASES UNDER MR. GOLDING-BIRD.

CORNELIUS	2.	Displaced internal semilunar cartilage and ruptured internal lateral ligament of knee.
	4.	Bullet wound in foot.
	8.	Stab in face.
	15.	Fractured femur.
LUKE	11.	Tuberculous ulceration of wrist.
	12.	Chronic otorrhœa. Mastoid disease.
	18.	Retropharyngeal abscess.
CHARITY	12.	? Foreign body in pharynx.
	13.	Varicose veins. Recurrent hæmorrhage.
	14.	Strangulated femoral hernia. Kelotomy.
	16.	Fractured femur.

CASES UNDER MR. JACOBSON.

ASTLEY-COOPER	21.	Bruised hip. Lacerated buttock.
CORNELIUS	3.	Fractured patella. Wired.
	5.	Crushed foot. Pirogoff's amputation.
NAAMAN	2.	Pyloric stenosis. Loreta's operation. Recurrence. Gastro-jejunostomy.
	5.	Abscess of thigh. ? Cause.
	10.	Tuberculous testis.
DORCAS	2.	Varicose veins.
	6.	Cleft palate and hare lip.
	9.	Appendical abscess. Drained. Appendectomy.

CASES UNDER MR. SYMONDS.

JOB	13.	Cervical adenitis.
	19.	Old tracheotomy. Persistent stenosis.
LYDIA	19.	Non-malignant stenosis of rectum. Dilatation.
	Cot D.	Rachitis. Bowed tibiæ. Osteotomy.
PATIENCE	14.	Cervical abscess. Broncho-pneumonia.
SAMARITAN	10.	Fistula in ano.

CASES UNDER MR. LANE.

LAZARUS	13.	Varicocele.

PATIENCE 14. Erysipelas of leg.
15. Septic osteitis of finger.
SAMARITAN 9. Cellulitis of arm.
11. Fistula in ano.

CASES UNDER MR. DUNN.

LUKE 4. Vesical growth. ? Villous.
CHARITY. 19. Abdominal tumours. ? Cause.
21. Rodent ulcer of nose.
PATIENCE 1. Septic scalp wound.
2. Sinuses in breast. ? Tuberculous.

CASES UNDER MR. FRIPP.

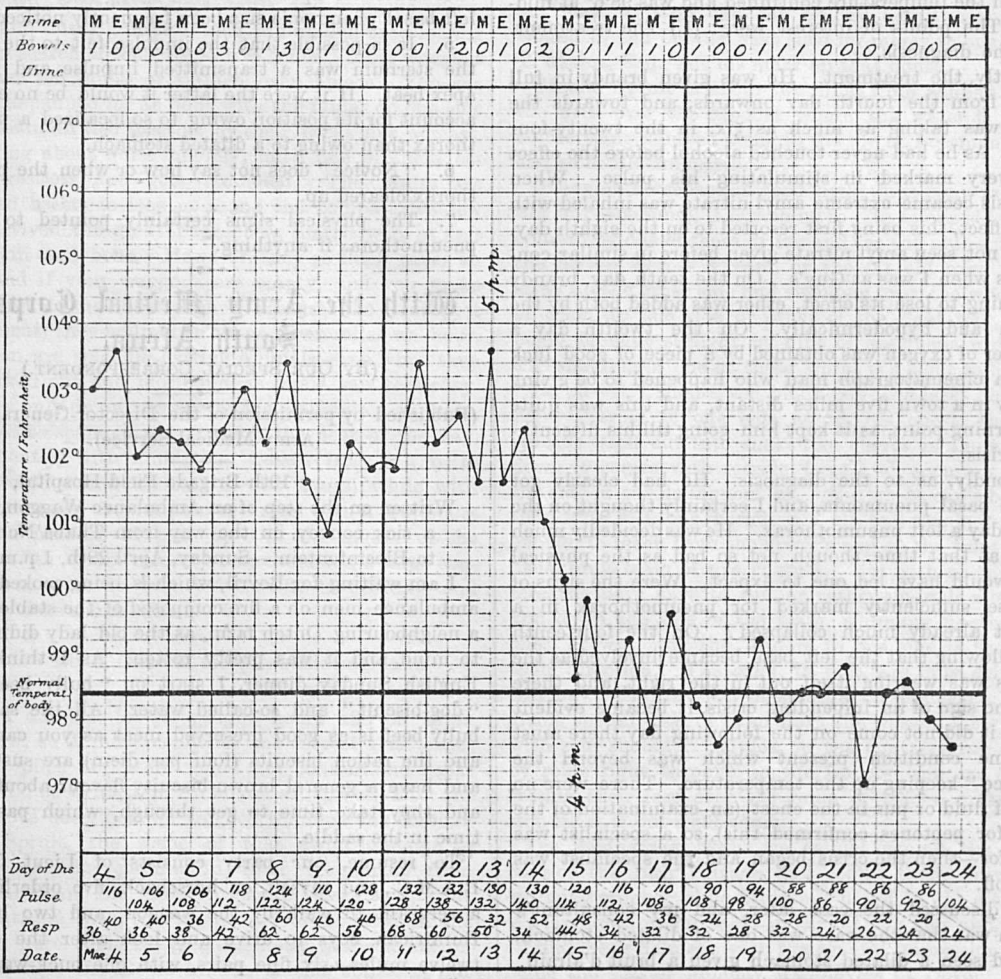
NAAMAN 19. Necrosis of phalanx of Hallux.
22. Inguinal hernia. Radical operation.
DORCAS 20. Hæmorrhoids.
Cot D. Nævus of breast. Excised.
PATIENCE 15. Cancrum oris. Excised.
SAMARITAN 12. Abscess of neck. Drained.

Case for Diagnosis.

X. Y. Z., æt. 18 years, was taken ill on March 1st with left basal pneumonia, which ran an ordinary course for the first five or six days, except that delirium was throughout exceptionally well marked.

On the seventh and eighth days the boy was decidedly worse. His pulse, as seen from accompanying chart, was 112–124, respiration 42–62, and delirium was more marked; cyanosis was increasing. On the eighth day a rub was heard in the right axilla, from which it was inferred that the right base was becoming involved, though, as patient was considered to be too ill to be turned over and examined carefully, the exact date of involvement of the right base was never rightly known.

On the afternoon of the ninth day the boy became appreciably worse. Restlessness and respiratory distress were marked, and his temperature fell 2·6° (from 103·4°–



100·8°). The pulse was very small and fell to 110, a lower rate than the last three days.

He now presented all the physical signs of pneumothorax over the lower lobe of the left lung in front and in the axilla. The percussion note was tympanitic, an extremely drum-like note, extending from fourth left rib above to costal margin below and from the left border of sternum internally to sixth rib in the mid axillary line. This note was different in character to that present over the normal stomach area. Cardiac impulse was in the fourth right space, this was taken to be the apex beat. Breath-sounds were absent over this area; the boy was unconscious and therefore voice-sounds could not be tested. There was a typical bruit d'airain, and well-marked metallic tinkling râles were to be heard.

His condition remained much the same, though he was gradually becoming weaker notwithstanding frequent stimulation, until the fourteenth day, when the temperature fell from 102·4° at 10 a.m. to 101° at 4 p.m., accompanied by profuse sweating. The next day the drop in the temperature continued and was 98·6° at midday. The points of interest were: (1.) The treatment. (2.) The diagnosis.

Firstly, the treatment. He was given brandy in full doses from the fourth day onwards, and towards the crisis was taking as much as ʒix. in the twenty-four hours. As he had never touched alcohol before the effect was very marked in stimulating his pulse. When cyanosis became extreme amyl nitrate was inhaled with good effect, this being first resorted to on the eighth day. I had not seen amyl nitrate given before in similar conditions when I was at Guy's. On the tenth day, brandy beginning to lose its effect, ether was added both by the mouth and hypodermically. On the twelfth day a cylinder of oxygen was obtained by a piece of good luck from a cinematograph man who happened to be giving a show in a town five miles distant, and this was quite the turning point, as it kept him going till his fifteenth-day crisis.

Secondly, as to the diagnosis. He had clearly got double basal pneumonia, and I certainly thought on the ninth day a left pneumothorax. He was decidedly much worse at that time, though not so bad as the physical signs would have led one to expect. Were the signs of collapse sufficiently marked for pneumothorax in a patient already much collapsed? On the fourteenth day, allowing that the left base became involved as the process was wearing itself out in the right, and there being no sign of an impending crisis, it became evident that if it did not come on the following day there must be some condition present which was beyond the "Novice" keeping up the temperature. There were no signs of fluid or pus in the chest (an examination of the urine for peptones confirmed this), so a specialist was wired for—then the crisis began and the specialist was wired off.

We discussed the case later, and my consultant's opinion was that the case was one of dilated stomach. We had seen a dilated stomach given a bruit d'airain, and it was improbable that the pneumothorax would be uncomplicated by a pyothorax of pneumococcal origin. The dilated stomach would account for a tympanitic note, even as high as the fourth rib, and for the absent breath-sounds. He failed to account for the metallic tinkling sounds, which were typical. "NOVICE."

COMMENTATOR'S REMARKS.

I certainly agree with the consultant for—

1. Though lobar pneumonia does occasionally give rise to pneumothorax, it is a very rare complication (F. Taylor—Osler).

2. A localized pneumothorax such as the physical signs could only suggest would be most uncommon.

3. If the pneumothorax had produced any symptoms at all, they would have been increased respiratory rate and probably a marked fall of temperature. In this case both pulse and respiration were slowed, and the fall of temperature was not excessive, but the patient may have been too ill to be influenced by the accident.

4. Increase upwards of stomach resonance in acute left basal pneumonia has been frequently noticed.

5. It is possible that the impulse felt to the right of the sternum was a transmitted impulse and not the apex beat. If it were the latter it would be no easier to account for its position owing to so localized a pneumothorax than owing to a dilated stomach.

6. "Novice" does not say how or when the pneumothorax cleared up.

7. The physical signs certainly pointed to a pyopneumothorax if anything.

With the Army Medical Corps in South Africa.

(BY OUR SPECIAL CORRESPONDENT.)

(Published by permission of the Director-General of the Army Medical Service).

19th Brigade Field Hospital,

Written on the step of an Ambulance Waggon, part of a sick convoy, on the way from Thaba'Nchu back to Bloemfontein,—Sunday, April 29th, 1 p.m.

I am waiting for Bovril, which is being cooked by our ambulance men on a fire composed of the stable door of a neighbouring Dutch farm, as the old lady didn't seem to mind, and it was pretty rotten. As I think of an English Sunday dinner, I start on "bully beef" and "dog-biscuit" and so-called water. All the same, the bully beef is as good preserved meat as you can want; and the ration biscuits (four per diem) are sustaining, and have a general brown-biscuity flavour about them, and they take time to get through, which passes the time in the saddle.

To resume, our party consists of Lieut. Martin, R.A.M.C., and myself, on horseback, five orderlies, and a sergeant to walk by the waggon, and two black or Eurafrican boys to drive and look after the span of twelve mules—six fine pairs, with one buck-waggon to

hold five tents and a minimum of surgical appliances and drugs. We and our little convoy on Monday took on board a conductor from the supply-park, and left Bloemfontein at 3.30. We had only twelve miles to go to Boesman's Kop, on the Ladybrand Road; but we did not get in till nine, and then they said we were *travelling so fast because we were alone!*

We reported our arrival per flash-light to the Major commanding our Bearer Company some miles off; but got no answer, and so retired to our valises on the veldt for the night. Martin and I had a fearful scramble in the dark up and down the kopje to find this signal, but were rewarded by a splendid view all round the country with flash-lights flashing messages from a dozen kopjes in divers directions. The next day we still had no orders until at 11 the Highland Brigade rolled up with their full transport and our P.M.O.; so we rolled along *after them. Soon after dark we halted for the night,* and the lonely, dreary veldt suddenly became a populous, noisy town, with camp-fires, tents, and waggons everywhere, and dusky groups of men, mules, and oxen loafing about in search of their respective grubs. Most waggons only have ten mules or sixteen oxen apiece. You see them outspanned for an hour with the mules on one side of the team all tied together by their necks five abreast, wandering about quite happily, until one of them becomes restless and gets strangled. The mules are wretched beasts to look at; and the comparative few who survived the great Paardeberg march were at first mere skin and bone. However, they go three miles an hour, and if your waggons are empty, and you make them trot (a heinous offence against the transport department) they will put in six or seven miles an hour. The oxen are splendid-looking animals, even when they are worked out and moribund, as one I saw yesterday. But they only do two to two and a half miles an hour, and must be spanned out through the heat of the day. Consequently, with mules one travels from 6 a.m. to 6 p.m. (with a mid-day halt of two hours), while with oxen you travel from 4 p.m. to 8 a.m. with a few hours rest from perhaps 11 p.m. to 3 in the middle of the night. With divers minor halts, therefore, a large convoy can at most do twenty-five miles in the day, and generally does about fifteen.

No. 9, General Hospital, Bloemfontein,
Thursday, May 3rd.

Here I am just for forty-eight hours and off again to-morrow, so I must condense the rest of this letter, although piles of letters would not contain the books that should be written, if I told you all. Well, after the night above described we trekked the next day through Mealie Spruit, the scene of that awful disaster to Col. Broadwood's column in their retirement from Taba'Nchu upon Bloemfontein, some weeks ago. The Dutch attaché with the Boers, before he died in the Raadzaal here, told one of our fellows that the excitement amongst the Boers hidden in this spruit as our convoy approached was intense. Any decent scouts would detect them, and they would probably be caught in a death-trap. Instead of which our fellows, thinking themselves secure within our own lines, came along singing jauntily and smoking their pipes, and he would have given pounds to have been able to stand up and shout "Cave." Even up to one hundred yards off this *spruit is unnoticeable; the level veldt appears unbroken.* On they came to within a few yards, and then they were greeted with the most fearful tornado of fire possible. And now, a fortnight after, we could see the remains of the looted convoy in every direction—broken meat and biscuit tins, the nose-bags of the horses, dead carcasses of horses and mules half decayed, and anything else they found useless. In return, we a fortnight later secured the waggon of, apparently, a Boer preacher, abandoned in the face of this our next advance. I send you some of his sermons in print, and also some pages *of a Dutch bible from an otherwise empty house close* to Mealie Spruit, belonging to one Pretorius—a wicked old man who on one day refused admittance to our wounded, and on the next sued for mercy to our people. T. Atkins, Esq., left his mark on that house.

Mealie Spruit is about two miles from Sannah's Post, the drift over the Modder where the water is filtered before being pumped along to the top of Boesman's Kop, and so to Bloemfontein.

Being on horseback (a good little Cape pony valued at £12 in peace time), it is ripping to rein to one side of the *column by one of these drifts, and see the mules fighting* the drivers across s ream, or the fat old oxen puffing away up the other side and swinging over, the whole line of them, to one side or other of the right way, before being brought straight by dint of assiduous whipping. The wielding of one of these whips is a sight to live for. "Ik, ph—tt," shouts the black boy; he jerks his upper hand sharply to one side across his chest, the lash spreads itself out into snake-like curves in the air, and down it comes with terrific force and accuracy across the side of the delinquent ox. The whips can't be more than forty feet long, handle and all, and this is just long enough to reach from the driver's seat to the front of the usual mule team of five couples. But with oxen, therefore, the boys have to run, or rather shamble along, up and down the side of the team, whipping up the lazy ones, or whipping the leaders to one side if they lose their direction. The oxen, in fact, are only driven in this way; the only way of steering off stones, etc., is by giving the tail-pair of oxen next the waggon a big heave with your shoulder. Mules, on the contrary, are driven by reins right through to the leaders, and are always *getting their legs over the reins or traces, making us* stop till it is put right again.

On Wednesday, 25th, we caught up all the transport of the 19th Brigade and found them drawn up on rising ground, while firing was heard in the distance. We lay down on our backs in the blazing sun and dozed off under our helmets, with the general impression of its being the Easter Monday Manœuvres at Dover. Then word came that it was safe for us to proceed, and the

whole mass of transport—six waggons abreast and as many deep—became of a sudden a perfect pandemonium; all the whips swinging round and about in the air, the boys shouting and yelling, and the waggons jolting over the ruts and ant-heaps. Then another stop; another letting loose the sluices; again a stop, and so on. In the end we learnt that the Boers on our left flank (north) had been harassing us considerably, and we had lost several men and officers, including four officers of Marshall's Horse (from Grahamstown), and Col. Otter of the Canadians—a splendid fellow, who they say will be made General of the Canadian Forces. We pitched tents and had to look after a few wounded straight away, including a poor fellow shot right through the head, who has since at least survived twelve miles jolting in an ambulance, and an operation by Mr. Makins on the top of it.

Thursday we were up at four again, and after breakfast, started off at sunrise, six, and pitched tents again a mile further on, behind a big kopje, preparatory to an engagement which did'nt come off. We disposed of a few sick and wounded to the Australian F. H., who were occupying a neighbouring farm, and they arranged to cart them back to Bloemfontein. Then we were free to move again at 11 a.m., and catching up the rest of the convoy, reached Taba'Nchu before dusk. There we were for four days, and had time to rest a bit and look round. It is a small town which used to be a large native settlement of 10,000 or so in mud kraals. But when their chief died in '84, and the Boers came and took possession, to the disadvantage of the inhabitants, most of them went off to Bechuanaland, as they speak the same language (Sechuana), whereas they have little in common with the Basutos, who are close by. Now there are only about 1,000 natives left, but a considerable colony of Dutch and English, the place being of some importance on account of the large flour mills twenty miles to the east of it, the flour having to pass through Taba'Nchu on the way to Bloemfontein. I had a long chat with the English parson there (an S.P.G. man, and a bachelor), a certain Mr. Crossthwaite, who has known the place since '82, although since then he was for seven years in Kimberley. He seemed an excellent type of the quiet, scholarly and gentlemanly missionary, and made light of his own hardships in this campaign. When asked by his flock to protest against the cutting down of trees for fuel by the troops, he realized that the fuel was necessary for the army, and only requested the General that the fruit-trees should be spared and the willows cut down, as the fruit-trees are long in growing again. The place was fairly well cleared out of its available stock by French's force a month ago, the force which retreated under Col. Broadwood and met with the disaster at Mealie Spruit. It was again visited by the Dutch troops passing through from the south just before our arrival this time, and when we came in it was practically empty and we have been unable to get even butter and milk, to which we had been looking forward. However, there are lots of sheep, goats, and cattle about, and a live sheep was served out to our section of the field hospital as our ration every day. Apart from that our rations consisted simply of biscuit and tea, and on the last day we were put on three-quarter rations. The Boer force was the same as that which, driven up from Wepener, was almost caught at De Wets Dorp, between Rundle's Division (8th) and French's cavalry. We hoped to get to Taba'Nchu before them, but their outposts had cleverly managed to delay us the previous day, and so they just got through northwards with all their convoy a few hours before our arrival. Since then our people have been out shelling their position on the kopjes just north of Taba'Nchu, and they in return got their Long Tom (a big Creusot gun), so it is said, and some Pom-Poms (Vickers-Maxims) to work on our troops, when they took up position outside the town. On Tuesday our column started out of the town on the road to Winburg, but when well on their way up the side of a slope, the whole convoy was unexpectedly exposed to a long-range shell fire, one of the shells falling into the middle of our Red Cross waggons. Fortunately the shells were practically harmless, dropping from a height and so simply spreading straight into the earth. They were all common shell, *i.e.*, shells which break into segments, and did not contain shrapnel. However, our column had to turn aside for a time, and on Monday night we were not allowed to strike a single light or have any fires going. On Tuesday our artillery soon put the Boers out of court and we were able to continue our advance, part of the general advances from here and from Taba'Nchu towards Kroonstad. Several of our men wounded on Monday were brought in during the night and on Tuesday morning; and we had to do our best for them out on the open, in readiness to move forward at any moment. There is no time now to describe any of the cases or one or two of the tussles for life that we had with some of them, usually in vain. In any case, if they did not die, they had to be removed to the base, however bad they were; and I was sent off to escort thirty of them down here. I had previously been doing convoy duty, having been sent off on Sunday morning to take twenty sick back to the Waterworks; slept there that night; and rejoined the column just after it had been shelled on Monday, at 6 p.m. On Tuesday afternoon I left again with these wounded, in five ox-waggons, one (the Gordons' mess-cart with oxen presented by Cecil Rhodes) containing poor Towse, who, in saving the day at Thaba Kopje, was shot through both eyes and blinded for life, poor chap. I gave the anæsthetic for him this morning here. He is the bravest officer, they say, in the Gordons, and was already recommended for the V.C. at Magersfontein. Well, we left Thaba Kopje at 4 p.m.; and except for outspanning four hours in the night and six yesterday mid-day, trekked on and arrived here at 11 p.m.

I buried one poor fellow, shot through the neck, when we outspanned yesterday. Now I must stop; the four orderlies I brought with me to look after the patients, my horse and I go by train to morrow to Karree, and thence by first convoy to join our Brigade, we hope at Winburg.

F. E. F.

Passim.

DESPITE the lack of sensational news from the seat of war, the casualty list steadily grows in length, and already we are learning in the costly school of experience that the worst enemy of an army in the field is itself. Four more Guy's men have lost their lives in South Africa, Professor Jones, of Owens College, Civil Surgeons Fitz-Hugh and Bryant, and Medical-orderly Hughes, and the work is not yet done. Perhaps this may be the end of our losses, which are very heavy in proportion to our numbers; perhaps, however, the tale will be yet greater. To whichever side the balance of fortune swings there is a duty which becomes incumbent upon us at home, and which we may in all seriousness consider now, while the sick still lie in the hospital.

To the memory of her sons who have fallen, both civil and military, Guy's must erect some lasting memorial. In our busy life we have no place for a monument, nor would our hospital be a fitting site for such a testimony; but we have a Chapel, and in that Chapel must be placed something to remind us of those who have fallen in the noblest paths of duty; something worthy of the men who have proved themselves worthy of Guy's. When the war is over, there will be much to be done, and in the whirl of the home-comings, of the welcomes and the congratulations, there is the danger that we may forget those who are sleeping out on the veldt. Therefore must we take action at once.

IN another column will be found a resolution of the Clubs' Union which is exciting a good deal of attention at the present moment. Briefly, the Union has decided to allow Lawn Tennis to be played at Honor Oak Park on Sundays on payment of a fee of sixpence. We cannot but condemn this action of the council. In the sanctioning of the use of the ground on Sundays it shewed a wise appreciation of the physical needs of the majority, but in demanding the payment of a fee from members for this privilege, it is initiating or rather condoning a most vicious practice. The principle of the whole thing is utterly wrong; either the ground is closed on Sundays, or it is open without any monetary consideration. No club executive should permit the sale of privileges; for some little time the football clubs have encroached upon the rights of members by the sale of fixture cards, and now the governing body is going still further and demanding money from members of the Clubs' Union for the use of its own property.

CONSIDER the actions of various large undertakings, public and private, and the futility of this rule will be apparent. The most enterprising, the most successful, and the most opulent places of public amusement are those in which gratuities and "extras" find no place. And in the conduct of municipal affairs, it has now been found expedient to adopt an equalisation of taxation, so that the whole body corporate pays the cost of improvements, which directly benefit only a small portion of the community. So in our clubs. If it has been decided that an increased expenditure is involved by the opening of the ground on Sundays, the burden should fall on the shoulders of the club as a whole, and not on those of individual members. As well might they demand a poll tax from those members of the cricket club who are fortunate enough to represent the hospital in her matches, for assuredly while the eleven is enjoying the use of the ground, there is no opportunity for other members of the club to play cricket thereon.

THUS, even if the new rule involves a financial loss, we have shown that it is injudicious to attempt any limited taxation. In the present state of affairs, the sixpenny clause seems flagrantly unnecessary. It is inserted apparently for the benefit of the ground-man, who alleges that he is detained on the ground by this Sunday tennis. Now, judging from recent events, members put up and take down the nets themselves; the work, therefore, entailed upon the ground-man is *nil*. In fact, there is little need for his presence at all if he provide someone authorised to issue and see to the return of the club property; and since he lives at the club-house, and would not conceivably leave the premises entirely unoccupied at any time, we fail to see how he is suffering the slightest inconvenience by the opening of the ground on Sundays. For these reasons, then, we consider the new rule as unnecessary and contrary to the interests of the members of the Clubs' Union.

HEROIC efforts are being made to clear the ground for the prize-giving, and order is slowly evolving from the once chaotic condition of the park. Now an unequal combat has commenced between the gardener and the Borough

sparrows—he sowing seed, they consuming it. Presently, if the birds permit, the brown earth will be clothed in green grass, but the time is very short, and the seeds must sprout bravely to make any show. Last year, it will be remembered, Cornelius ward was newly finished and on view. Since then very many improvements and alterations have taken place, but by a curious coincidence, the other accident ward, Astley-Cooper, will be just completed and, no doubt, the chief attraction for the visitors. It will be a welcome relief to the police when old Mary ward is emptied of its present occupants; it is no sinecure for a couple of men to carry a loaded stretcher up the two flights of medical stairs.

THE holders of the Lawn Tennis Trophy, St. Bartholomew's Hospital, had very little difficulty in dashing our hopes to the ground. The only explanation of our defeat is to be found in the candid statement that our opponents were much too good for us. There are a few more cups and things to be decided, and perhaps our luck may be in the ascendant in one or other of these. Meanwhile we are attempting to curb our delirious joy at the welcome news that Guy's holds the Chess Cup for three months—an honour shared by the other competing hospitals.

WE have received a copy of an address delivered at Manchester by Dr. Edward Jepson, ex-Mayor of Durham, on the need of proper medical organisation. In a comprehensive survey of the whole conditions of the medical profession, Dr. Jepson advocates with considerable eloquence the necessity for some society by means of which medicine can assert itself both ethically and politically. It must be admitted that at first sight the framework of the organisation or association which is built up in the address, suggests strongly a Trades Union, bereft of its labour attributes. With a permanent secretary, whose duties must blend those of a commercial traveller and a parliamentary whip, Dr. Jepson thinks sufficient cohesion might be obtained among local medical protection societies, to force the British Medical Association into activity. Finally, the control of the General Medical Council would be obtained, and the organised society would seek efficient representation in Parliament. It is a huge project, but by no means impossible; it remains to be seen whether the projectors will be able to influence the next British Medical Association, at Ipswich.

THERE has arisen a habit, chiefly among junior men, of smoking anywhere and everywhere in the school buildings, irrespective of notices to the contrary. Perhaps the most flagrant instance of this insubordination is to be found in the custom which has transformed the wax model museum almost into a smoking-room. It must be universally known in the hospital that the collection of dissections which we possess is quite unique, and that in the event of any accident befalling a specimen, it could never be replaced. It should, therefore, appeal to everyone to restrain from any practice that questions in the slightest degree the safety of the museum. We have, all of us, a common interest in the school property, and in that interest we should not allow any action that is capable of damaging our common property.

TO-MORROW is Hospital Sunday. Our good friends the daily Press are appealing with eloquent voices to the charitable public, lest they should allow the very just and necessary claims of the Patriotic funds to completely swamp the equally pressing claims of the London hospitals. Meanwhile certain persons representing various ridiculous societies are publishing and distributing dirty little libels on the great hospitals, with the object of diverting money from these legitimate channels into their own miserable little coffers. We sincerely hope that an intelligent public, with the help of an intelligent press, will treat these attacks with the contempt that they merit, and not suffer their charity to be diverted from legitimate objects to the support of any collection of unreasoning faddists.

LAST Thursday we were treated to what the agriculturists would term "fine growing weather," and under the most abominable conditions conceivable, our Annual Athletic Sports were held at Honor Oak Park. Despite the fact that five minutes without an umbrella brought the rain to your skin, despite the floppy, oozy, muddy—clay-mud, too, which is the very worst—condition of the ground, there was a really excellent attendance; very small, very select, very enthusiastic. Mrs. Bryant pluckily stood to her promise and gracefully distributed the prizes; the junior staff turned out in strength and did yeoman service, while Mrs. Steevens, the Assistant-Matron, Sister Accident, Sister Patience, and a few courageous Nurses, scorning wind—of which there was none—and rain—of which there was plenty—left the shelter of the pavilion and

entered heartily into the spirit of the proceedings.

It was worth all the trouble, all the discomfort of that afternoon to see Mr. Higgens win the donkey-race. In the absence of the President, Mr. Higgens had consented to play the part of host; more than that he had promised to take part in the "Scurry Stakes," and, like the true sportsman that he is, a little rain was not going to deter him from turning out. He won his heat, and he won the final, and there was no more popular winner that day than he. Too much praise cannot be bestowed on the two Sports Secretaries; with everything against them, by dint of sheer pluck and tremendous hard work they secured good fields, good competition, and to us at least, a good afternoon's entertainment. Messrs. Roper and Trail are distinctly to be congratulated on this year's Sports.

In the forthcoming election to fill four vacant seats on the Council of the Royal College of Surgeons, Mr. Clement Lucas and Mr. Golding-Bird are both candidates. It will be unnecessary to suggest to Guy's men how they should vote on this occasion.

The largest item of expenditure in the balance-sheet of the Clubs' Union, is the "grant to the Guy's Hospital Gazette." It may as well be pointed out here for the information of our readers that, strictly speaking, this is not a grant at all. By an agreement entered into between the Gazette and the Council of the Clubs' Union, we agree to supply members of that Union with copies of this journal at specially reduced rates; that is to say, so far from that sum of money being a grant from the Council to us, it is in reality a necessary expenditure in purchasing copies of the Gazette for distribution amongst the members of the Union. By virtue of our agreement, therefore, the "grant" becomes a minus quantity, and should rather be considered as made by the Gazette to the Clubs' Union and not in the contrary direction.

We hear that two members of the Staff are shortly to be married. Mr. Steward and Dr. Cleveland will carry with them the heartiest congratulations from all Guy's men.

The following communication marked "important" has been handed on to us. We publish it without comment:—

"There will be a 'Students' Night' at the 'Shaftesbury Theatre' on Wednesday evening next, June 27th, in honour of Miss Edna May. An 'American Beauty' is shortly to be withdrawn—and as Miss Edna May has again promised to sing for us at the Middlesex Hospital Smoker in November next (to which we hope you will all turn up in force)—we wish to shew her this small indication of our esteem.—Gentlemen are requested to bring flags and not to make too much noise with their inevitable tin trumpets during the songs. These were much in evidence at 'San Toy.'

Please come in force

Gallery entrance—Shaftesbury Theatre—6 p.m., Wednesday, June 27th.

Robert R. Lewis,
Middlesex Hospital.

We hope that our supporters of 'Students' Nights' have not all gone to the 'Front.'"

Congratulations to Mr. McGavin on his success in the Final Examination for the Fellowship of the Royal College of Surgeons and to Messrs. Rowlands, Anderson, Henderson, Hicks, McLachlan, Robertson and Tuohy on the result of the Primary Fellowship.

Nursing News.

Matron's Office.

During the months of July and August, several of the Sisters will be away on their summer holidays, and it is hoped that everyone will have fine weather. We are very sorry indeed to hear that Mrs. Strathern will be unable to help us this year as usual. Miss Anson, Mrs. Lyon, Miss Plummer, Miss B. Howlett, Nurse H. Newton and Nurse Martyn, all of whom have received their training at Guy's, will act as holiday sisters.

On June 20th, Probationer Bridges (Isolation) left the hospital at the end of her three years' training, to take up work at Guy's Private Nursing Institution, after a short holiday. Probationer Kew has been appointed Head Nurse in the Isolation ward.

From the Gazette's Special Pathologist.

T. E. D. H., Reigate.—Tubercle bacilli are present in the sputum in very small numbers.

H., Ramsgate.—Tubercle bacilli are present in the sputum in considerable numbers.

J. E, Middlesborough.—No tubercle bacilli were found in the sputum.

PATHOLOGIST.

Some Notes on the Imperial Yeomanry Hospital.

Imperial Yeomanry Hospital,
Deelfontein,
May 14th, 1900.

Though there are still two of the English huts unfinished, this hospital has in all other respects reached, at last, its full state of development, and I thought you might like to have a short account of some of the main features. The appended plan of the hospital grounds has been prepared by Dr. Barclay Black, and with that plan in front of me I have jotted down a description of the various parts of the hospital as one meets them in taking any visitor for a tour of inspection. This doctor, who is my staff officer, superintends all the work of the camp-cleanliness and latrine departments. His plan, not being the work of a skilled surveyor, does not pretend to be of more than approximate accuracy as to distance, but it is at least faithful in intention and in effect.

To take, first, the smallest half which lies to the right of the railway line as you arrive from Cape Town, the following departments are seen:—

1. The group of isolation tents, for, like other base hospitals, we have not been exempt from the occurrence of an occasional case of scarlet fever.

2 indicates the position of the tents of the medical staff, the two marquees being occupied by the ten surgeons' dressers.

3 shows the bell-tents occupied by a detachment of about a hundred orderlies. They are seen to be separated from the doctors' tents by the main drain, and also by the main road which leads from the wards to the main latrine (labelled 7). The main drain is made of four-inch earthenware pipes, and is fed by various sinks throughout the hospital grounds. No solid matter is allowed to be thrown into the sinks, nor infected water from the Enteric Section—this is all carried by our natives along the route indicated, not far from the laundry to the dumping ground—nor greasy water from the kitchens—this is used to feed the pigs—nor does the drain go near any latrine, nor any water-supply pipe. Practically the only thing thrown down the sinks is water that has been used for washing. The main drain discharges by means of a system of sub-dividing trenches on to a part of the veldt which has a good incline away from the hospital.

Between 3 and the railway line is placed a galvanised iron building, which is sub-divided into a central dry canteen for the detachment and two lateral compartments forming workshops for the carpenters and painters respectively.

5 is a large tent used as a messroom, recreation room, and bathroom by the detachment.

6 represents a collection of hospital marquees which are used only when the hospital is over full, for the temporary accommodation of convalescent patients awaiting a train for transfer to Cape Town.

7 is the main urinal and latrine. It has separate compartments for the sergeants, the detachment, and the hospital patients, and we consider it a masterpiece for the Karroo. The floor is cemented throughout, and for four feet outside the corrugated iron walls it is inclined and grooved so efficiently that the four natives who are perpetually on duty there can, when they are not busy carrying buckets away to the dumping ground, frequently flush out the whole enclosure by means of an armoured hose which has a good head of water from a stand-pipe. The washings are collected in a cement-lined pit just outside, and are thence removed in buckets to the dumping ground. No buckets come back from the dumping ground to any part of the hospital without having undergone a prolonged soaking and subsequent thorough cleansing in a large tank of disinfectant at the dumping ground. The bedpans and bottles from all patients in the hospital who are not able to walk to this latrine are carried thither by the orderlies, and left in a special annexe, clean utensils being taken back to the wards in their place. The excreta are removed to the dumping ground by the natives from 6 a.m. For the Enteric and Dysentery Sections special disinfecting latrines are provided, as will be described later on.

8 is the situation of the laundry, close by which are:—

(*a*) A Washington-Lyons disinfector capable of dealing with nine mattresses and many smaller articles in each batch.

(*b*) A Russian bath for the treatment of stiff limbs, which are so frequent both from rheumatism and from injury.

(*c*) A blacksmith's forge.

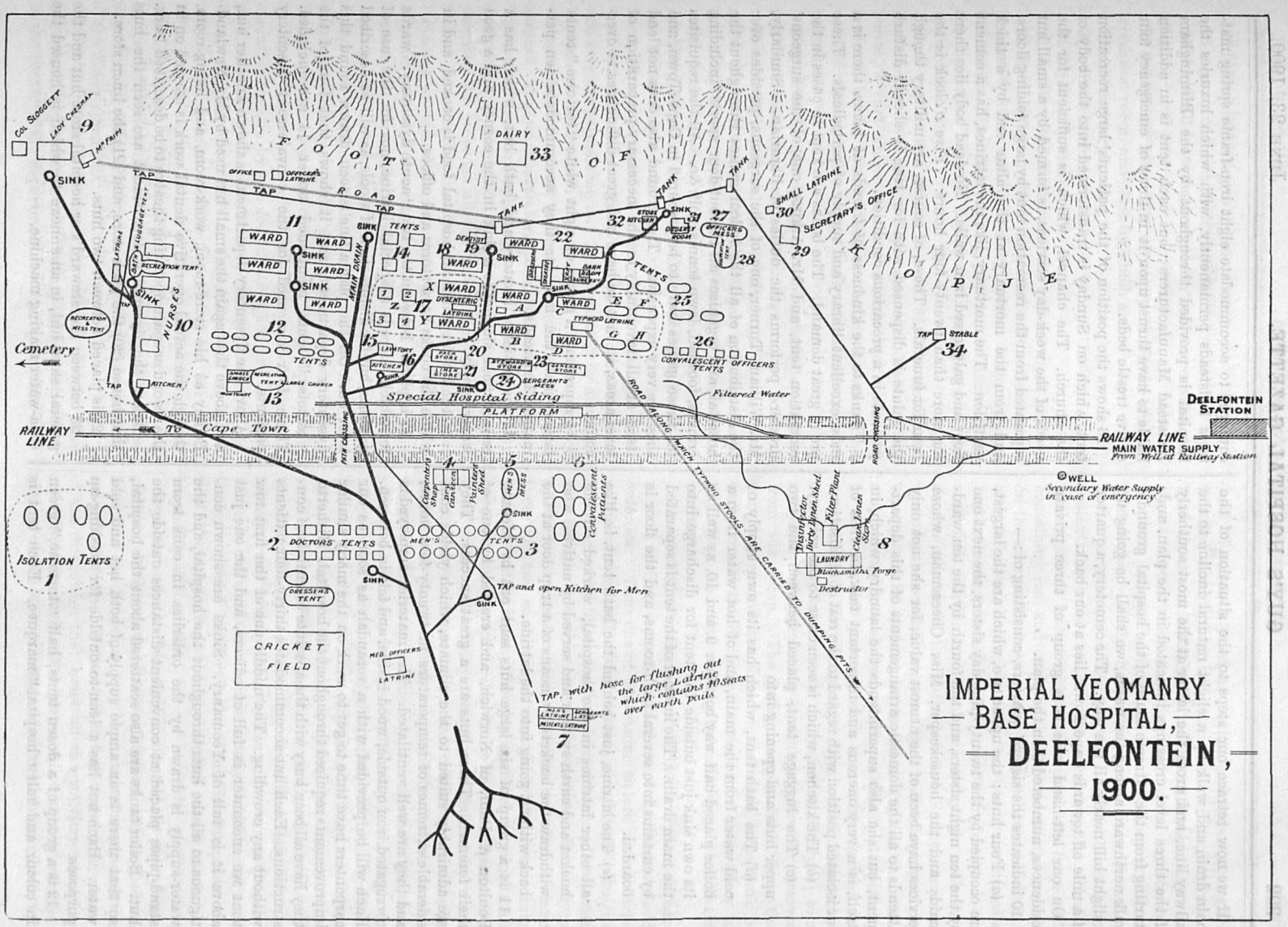
(*d*) A refuse destructor, through which all paper, straw, small boxes, empty canned meat tins, and other camp litter are passed; the ash is then buried.

(*e*) A large filter plant by De Gries, driven by steam from the laundry, and large enough to cope easily with all the drinking water of the hospital.

The laundry plant is a large and efficient one by the same firm and is worked by men sent out by that firm, helped by four of the wardmaids and some fifteen natives. It easily deals with the washing of the seven hundred white individuals at present in our camp. All of this plant is housed in corrugated iron sheds.

All mattresses, bedding and linen from the enteric and the other infected wards are put through the Washington Lyons Disinfector at seven o'clock in the morning, having been stored if necessary overnight in an annexe of the enteric latrine between the enteric huts.

The last point of note is the secondary well which has been sunk on the way to the station as a standby in case of emergency, but this water-supply we have not yet had to fall back upon, as that from the railway well at the station has proved amply sufficient for our needs.



IMPERIAL YEOMANRY
BASE HOSPITAL,
DEELFONTEIN,
1900.

If we now retrace our steps to the situation of the main drain and walk up a slight natural incline to the railway line, and cross the latter at the most southerly of the three level crossings indicated in the plan, and, starting from the extreme south of the hospital grounds, walk northward among the wards, we shall be going up a slight hill nearly all the way. The cemetery, a quarter of a mile off towards Cape Town, lies at our back.

On our left-hand side is a group of three private residences, numbered 9 on the plan.

10 indicates the sisters' quarters, consisting of:—

(*a*) Four huts; the upper two, which are the largest, are occupied by the twenty-nine day sisters, the next one by the ten night sisters, and the fourth by the ten ward-maids and the housekeeper, Miss Cheeseman, whose services have been of the utmost value, for she not only attends to all the domestic arrangements of this department, but she also superintends the laundry, which, in itself, is a very onerous and important task, in view of our isolated position with regard to the rest of civilisation.

(*b*) The kitchen, which is seen close to the railway.

(*c*) The luggage tent, placed between the two upper huts and opening into

(*d*) The bath tent, which has its own supply of cold water from the main, and of hot water from a boiler placed half way between 9 and 10, as well as its own sink just outside the tent for discharge into the main drain. The interior of the tent is separated by curtains into several bath-rooms, and the floor is boarded.

(*e*) The latrine, just behind the bath tent, is, like all other latrines in the hospital, worked on the bucket and earth system and served by natives, who withdraw the buckets by means of a trap door at the back without going into the latrine.

11 is a group of six large huts sent out by Messrs. Boulton & Paul, of Norwich, and erected by one of their foremen. These huts are a great success. They are admirably suited to the climate, which yields considerable extremes of temperature in twenty-four hours, and they are well ventilated. The material employed is corrugated iron outside, wood inside, and felt in between. Each will be provided with a verandah as soon as our carpenters have time to get to work on the many similar improvements required throughout the hospital. Hitherto they have all been busy with the absolute essentials of constructions. Each hut accommodates thirty-four patients without any crowding. The middle one of the first row that we encounter is full of officers, and the one just above it is full of Yeomanry. Sinks are shown contiguous to all the huts throughout the hospital, and the water-supply is drawn by the orderlies in cans from stand-pipes placed at convenient distances outside the hut. Boiler tanks are also scattered about the hospital, so that there is an ample supply of both hot and cold water. Each hut has a lean-to outside for washing-up purposes.

12 is a group of a dozen tents, half "tortoise," green in colour, and half "hospital" marquee. Each tent is equipped to accommodate eight iron-frame spring mattress bedsteads permanently, with which luxuries the hospital is provided throughout by the Birmingham Bedstead Manufacturers; but each tent is in addition liable to have thrust upon it in times of emergency four or five trestle beds.

13 shows the position of the patients' large recreation tent, which on Sunday is transformed into the body of the church. The chancel, which is sufficient for the needs of the week-day services, is formed by a small hut separated from the recreation tent by large folding doors, and from the mortuary at the altar end by a thick partition. The mortuary, like the latrines, has a cement floor and galvanised iron walls. No dead body lies there for more than twenty-four hours. Five o'clock is the hour for funerals. These, of course, are military though the salute is dispensed with for fear it should disturb patients in a precarious condition.

Thanks to the kindness of friends at home, there is a most excellent library and supply of periodicals. These are in great demand. The books are kept in cases in the recreation tent, and Mr. Atkins, one of the surgeons' dressers, performs the duties of librarian. Similarly, Mr. William Turner, one of the surgeons, presides over the distribution of all the indoor games throughout the hospital, and organises all the out-door sports, including cricket, football, lawn tennis, golf, &c. All the requisites for these games have to be procured in Cape Town, and they are very expensive. The ground also does not lend itself at all favourably to the necessary preparation of level areas, so that we have had great difficulties to overcome.

14 represents a group of eight white "tortoise" tents larger than the last, for they accommodate ten permanent bedsteads.

15 the patients' lavatory and bath hut, which has a cement floor sloping to a sink in the corner, and a good water-supply.

16 the hut in which all hospital food is cooked, and in which the cooks have stores and offices.

17 is placed between the two "acute dysentery" wards for which there is a special latrine, not for the use of patients, but for disinfection of stools, as will be described later on. On the plan a line is seen drawn round this dysentery department, and it shows that four of the "tortoise" tents mentioned under 14 are included. These four are used for the convalescent dysentery patients.

Above the dysentery department is shown another hut, and above that again the small hut used by Mr. Newland-Pedley as his store-room, work-room, and living-room, though the actual operative dental work is carried on in the second or spare operating theatre to be described later.

Below the dysentery department are seen the huts that house (20) the pack store, and (21) the linen store.

22 is placed between two huts.

23 between the steward's or hospital store hut and the general store hut, in an annexe to which is housed the soda-water making machine.

24 indicates the sergeants' mess tent.

25 a group of five convalescent tents.

26 the small tents, each of which house a convalescent officer.

27 the officers' mess, into which opens 28, the officers' recreation room, and close by which are

29 the secretary's office,

30 a small latrine,

31 the orderly room,

32 the store and kitchen for the officers' mess, and

33 the dairy, from which the milk for the entire camp is dispensed after sterilisation by several large Aymard sterilisers. Miss Brereton, in addition to her work in the operative surgical department, presides over the work of the dairy.

Half way to the station is seen 34, the stable and coach-house. A couple of Cape carts, each drawn by two horses, a cart which carries the linen backwards and forwards to the laundry, and the riding horses of the various officers, both medical and combatant, are here housed.

This leaves for description only the enteric department and the cross-shaped surgical building.

The cross-shaped building labelled 35 in the plan shows the operating theatres, the surgery and dispensary, the X-ray department, and the surgical store. The latter forms the head of the cross, and, with the two operating theatres, is in the charge of Miss Brereton, late Sister Bright. In her surgical store are accumulated all the supplies of instruments, dressings, antiseptics, anæsthetics, splints, trusses, and other medical and surgical paraphernalia. It is separated by a roofed-in open-air lobby from the operating theatres, one of which is devoted, except in times of stress, to the dental surgeon. The two theatres form the short arms of the cross. The theatre used for surgical operations is most admirably equipped and furnished, Messrs. Down Brothers, who executed the order for all the instruments, having presented a complete set of aseptic metal furniture, including washhand stands, stools, dressing tables, and a splendid raise-and-lower table. The wood lining of the theatre has been painted white. There are two large slabs of corrugated glass which give an excellent top light. The wooden floor is covered with linoleum, the doors are four feet wide, giving easy access for the bearers from the open air or from the X-ray department. The long limb of the cross is also separated from the operating theatre by a roofed-in air space and is occupied, as to the end nearest the operating theatre, by the X-ray department (which is singularly well equipped and is doing most excellent work under Mr. Hall Edwards), and as to the foot of the cross by the surgery and dispensary. The photographic dark room is placed in the farthermost corner of the dispensary, so that the large store of plates shall not be spoiled by the proximity of the X-ray apparatus.

36 is the Enteric Section. It consists of four huts accommodating twenty-two to twenty-six patients each. In the centre of the department is a corrugated iron hut, half of which is used as a disinfecting latrine for the infected excreta, and the other half for the storing of used linen and bedding, including mattresses, until the regular hours which are appointed for the transference of these infected articles to the Washington Lyons Disinfector. All the bedpans and urine utensils used in the department, and also all the water with which the patients have been washed, are carried by the orderlies to this enteric latrine and there emptied into large pails containing izal and disposed on the concrete floor, while on the zinc shelf there are sets of zinc baths labelled A and B for the thorough disinfection of all the utensils. In the baths labelled A the utensils are swabbed out with izal solution, and then they are put to soak in a similar solution in the baths labelled B until required again in the wards. An intelligent native is perpetually on duty at the typhoid latrine swabbing out the walls and floor and iron shelves, which are all sloped especially to facilitate this process, while two other natives are continually on duty carrying the pails of the disinfected excreta away by the route indicated on the plan to a special dumping ground in a natural hollow far removed from the camp. The pails brought back from the dumping ground are fished out from a large tank of carbolic and the dirty ones are put in their place to to undergo a similar soaking before they go back to the latrine.

The staff of attendants on duty in the typhoid department is entirely separate from the rest of the sisters and orderlies. Thus one of the senior sisters is in charge of the nursing staff, which consists of a day and a night sister for each hut, and a day sister for every two tents and a night sister for every three tents. Similarly a special ward master is in charge of the orderlies, of whom there are two on duty with each sister and one on duty with each night sister. The day staff and the night staff are each on duty for twelve hours in this department, their occasional holidays being arranged for by there being always one extra sister and two extra orderlies in addition to those already mentioned. By this means not only is efficiency conduced to among the attendants of the department but also uniformity in the methods adopted for carrying out the rules which have been printed and circulated to every attendant and which are strictly enforced. There is a special hut between the two left hand wards for the use of all sisters engaged in the department, and here they have their tea, &c., for taking of any food by the attendants, or even its preparation, in the wards is of course strictly forbidden. There is also a special lavatory for the enteric attendants so that they may be able to disinfect their hands as frequently as they like.

As a postscript to this short account of the plan of our grounds, those interested in our hospital will be glad to hear that the longer we stop here the more pleased we are with the site. We are not free of course from many of the difficulties that beset all the military hospitals out here in common. For instance, we have to struggle with a very heavy visitation of enteric fever, which, by

demanding the services of so many of our male and female staff, throws a heavy strain upon our resources, for we have only a hundred orderlies to the one hundred and sixty of a General Military Hospital. Also our sisters often find it heart-breaking work to sustain the unequal battle against the never-ending invasion of vermin brought down by each train load from the front. We are harassed too by the fact that the supply of milk is precarious and that eggs are extremely scarce. Fruit and fresh vegetables except potatoes and onions, are absolutely unobtainable. On the other hand, we have many things to be thankful for. Our water-supply is unimpeachable. The climate is most healthy, sunny and warm in the day and as yet not very cold at night. The distant scenery is distinctly attractive. Our specialists in Ophthalmic and Dental Surgery and X-ray work have proved a godsend. The same may be said with the utmost truth of our larger than usual body of nursing sisters. Nor must our masseur be forgotten. His assistance has been most efficacious in many cases of fractures and stiff joints and withered muscles. Again, it is a tremendous pull that we are able to do all our own washing, and that we have a really efficient steriliser, which can tackle, even though we are isolated in the Karroo, the otherwise unsurmountable difficulty of wholesale disinfection.

Last, but by no means least, we owe much to our position of "splendid isolation." For nearly thirty miles on each side of us there is no sign of civilisation, except a few ostrich and grazing farms. There are no troops except the necessary guard of fifty, to soil the ground, the water, or the air. For this reason we suffer less than most places from dust. We enjoy an immunity from outside interference which will be readily appreciated by all those who are in a position to realise what an amount of hard work has to be got out of the staff, and how easily the harmonious working of a large volunteer staff, such as ours is, could be upset, or at least hampered by the existence in our neighbourhood of any factors capable of still further complicating the many interests which have to be considered in the running of such a hospital.

Not a few ladies, devoted to good works but possessing no technical training, have come out to South Africa on purpose to "help in any capacity" in the military hospitals, but the explicit instructions we have received from the committee in London for whom we act, no less than the fact that there is not a room which they could hire for their accommodation within twenty-nine miles of us, has saved us from the unpleasant duty which might otherwise have devolved upon us of telling these willing but unwanted souls that after a considerable experience of the value of their kindly-meant offers, and after the fullest consideration, we would very much rather have their room than their company.

ALFRED D. FRIPP,

P.S.—Of course, we should not have put the enteric patients into the wards so close to the operating theatre *if* we had not been flooded with them before any other accommodation was available, but as a matter of fact we have not had cause to regret this proximity. It is not always easy to forecast events out here!

The Medical, Surgical and Hygienic Exhibition.

THE fourth annual exhibition of medical, surgical and hygienic appliances, which was held in the Queen's Hall, Langham Place, was opened on June 5th, and continued during the three following days. The exhibition was a great success from all points of view. The stalls were tastefully arranged, the hall looked very bright and pretty, and the attendance was greater than on any previous occasion.

Surgical instruments were shown by Messrs. John Weiss & Son, of 287, Oxford Street, London, who made a speciality of an appliance for easily sterilising instruments and dressings. Messrs. Maw, Son & Thompson, of Aldersgate Street, London, exhibited all kinds of instruments and dressings, including a great number of recently introduced appliances. Mr. Thomas Holland, of 40, South Audley Street, Grosvenor Square, London, showed a sock which promises to be of great value for flat feet. It is made in three forms, depending upon the severity of the condition, and it has a great advantage over all other appliances for flat feet in that it can be removed from one boot to another. It has been used and recommended by Mr. Treves and Mr. Pickering Pick.

The representatives of Izal made much of the fact that 9,000,000 gallons of this fluid had been ordered for the use of the army in South Africa, and Messrs. Welford & Sons boasted that they had supplied the army with some of their products—humanized milk and also the milk of the ass. The exact destination of the latter was not given.

The stall of Mr. E. Merck, the well-known Chemist, of Darmstadt and 65, Jewry Street, London, E.C., contained an exhibit of dionine, a drug which is reported to have an action similar to morphine without any of the disadvantages of the latter drug, at the same time possessing special therapeutic properties of its own, particularly that of being a preparation useful in cases of morphinism. He also showed new preparations of iodine and bromine, which are in combination with sesame oil. These bodies very rarely produce symptoms of iodism and bromism, and thus have a marked advantage in this respect over the iodine and bromine salts.

There were many firms exhibiting natural foods, but of these Plasmon claimed most of our attention. This body is very soluble, and unlike many medical foods is perfectly tasteless and odourless. We should think it might be profitably used for nutrient enemata as well as internally for patients suffering from typhoid fever, etc., and after abdominal operations.

Among the publishers who showed their newest books we specially noticed Messrs. Rebman and Messrs. Bale, Son & Daniellson, of Great Titchfield Street, Oxford Street, London.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants.—Messrs. H. Durbridge, D. Forsyth, J. M. Brydone, T. P. Thomas, T. E. Holmes, J. S. Steele-Perkins.

Clinical Assistants in Medical Out-Patients.—Messrs. L. E. Stamm (Dr. Shaw); J. A. Butler (Dr. Bryant); A. W. Talbot (Dr. Fawcett).

Obstetric Dressers.—Messrs. D. L. Morgan, H. McD. Parrott, E. J. F. Hardenberg, R. S. Roper (July 1st); F. W. Smith (August 16th).

Dressers in the Throat Department.—Messrs. T. J. Wright, G. Lewin, F. W. Sime, R. Tilbury, G. Clarke, T. H. B. Dobson.

Assistant Surgeons' Dressers.—Messrs. G. B. Churchill, M. Coplans, F. Richmond, H. A. Cutler, J. W. Gromitt, J. C. O. Bradbury (Mr. Symonds); A. D. E. Kennard, E. J. Crew, J. C. Curtis, A. H. Turner, R. T. Collins (Mr. Lane); D. S. Graves, W. H. Bowen, A. H. E. Wall, M. W. Cohen, W. G. Parker, H. Barber (Mr. Dunn); C. H. Gask, A. Croneen, W. A. G. Stevens, T. G. Miles, G. Moir, G. F. Humphreys (Mr. Steward).

Medical Ward Clerks.—Messrs. W. C. Lewis, F. M. Vincent Smith, G. B. S. Soper, F. L. Thomas, A. J. Beadel, N. N. A. Houghton, W. W. C. Jones, A. E. H. Pakes, G. E. Malcomson, P. N. Blake Odgers, F. H. Parker, A. J. Urquhart, A. W. Iredell, L. G. Nash, F. J. Turner, W. H. Cole, E. Faulks, H. T. Palmer, J. D. Pearson, T. M. Smith, M. C. Wetherell, C. J. Pinching, O. B. Travers.

Assistant Physicians' Clerks.—Messrs. C. E. Bartlett (Dr. Shaw); R. H. Terry (Dr. Washbourn).

Surgical Ward Clerks—Messrs. H. R. Grellet, C. H. Robertson, W. E. J. Tuohy, C. E. Adams, K. Anderson, J. B. Copland, C. M. L. Cowper, C. H. Denyer, J. T. Hicks, S. L. Pallant, A. P. Piggot, H. L. Shelton, G. W. Smith, H. Tipping, W. L. M. Day, B. Glendining, L. H. Moiser, C. M. Murray, E. W. Strange.

Clerks in the Skin Department.—Messrs. J. A. Butler, F. G. Cross.

Dental Surgeons' Dressers.—Messrs. P. W. L. Camps (July-August); E. G. Wales (August-September); E. G. Andrew (September-October).

Clerk in the Electrical Department.—Mr. P. S. Mandy (July-August).

Pathological Assistants to Surgical Registrar.—Messrs. H. S. French, F. W. Sime.

Pass List.

Royal College of Surgeons of England, May, 1900.

FINAL FELLOWSHIP EXAMINATION.

L. H. McGavin.

PRIMARY FELLOWSHIP EXAMINATION.

K. Anderson, E. E. Henderson, J. T. Hicks, A. R. McLachlan, C. H. Robertson, Robert P. Rowlands, W. E. J. Tuohy.

University of Cambridge.

EXAMINATION FOR THE DEGREE OF DOCTOR IN MEDICINE.

W. J. Harris, M.A., M.B., B.C.

Guy's Hospital Clubs' Union.

THE Council of the Clubs' Union have made the following Bye-Law:—

The ground at Honor Oak Park shall be open for tennis, etc., on all Sundays during the summer season until 6.30 p.m. Every member taking part in tennis or any other game on a Sunday, shall previously purchase a ticket from the groundman. The cost of a single ticket is 6d., of a season ticket 7s. 6d.

F. J. STEWARD, *Hon. Sec.*

Sport.

Cricket.

GUY'S 1ST XI. v REIGATE.

Guy's batted first at Reigate on a rather wet wicket, and by means of consistent scoring made 274; our opponents replied with 205, of which total F. Nightingale made an excellent 106. Guy's thus won by 69 runs. Score:—

GUY'S.

F. C. Wetherell, b Morrison	31
J. M. Brydone, b Budger	41
R. C. Poyser, c Budger, b Turner	36
H. Barber, b Morrison	37
K. V. Trubshaw, b Elphick	29
H. M. Langdale, c English, b Turner	20
G. S. Graham-Smith, c sub, b Turner	43
M. C. Wetherell, b English	11
E. A. Collins, not out	10
C. M. L. Cowper, c Longhurst, b Turner	1
C. W. Strange, b English	0
Extras	15
Total	274

REIGATE.

E. A. English, b F. C. Wetherell	23
E. Nightingale, run out	27
W. S. Turner, c Wetherell, b Cowper	0
H. Budger, b Strange	13
F. Nightingale, not out	106
Elphick, b Trubshaw	10
F. Morrison, b Poyser	3
W. A. Moses, st Graham-Smith, b Poyser	0
S. Longhurst, st Graham-Smith, b Poyser	0
A. Reigate, c Graham-Smith, b Poyser	7
Extras	16
Total	205

GUY'S 1st XI. v. ELTHAM.

This match was played at Eltham on Whit-Monday, and resulted in a win for the Hospital by 18 runs. We looked like getting beaten until Bowle joined Barber, the latter made a very good 55; Bowle was very steady at a critical moment. Score:—

ELTHAM.

C. H. Hunter, c & b Cowper	1
A. S. Jackson, lbw, b M. C. Wetherell	42
F. D. Logan, lbw, b Cowper	3
R. Haywood, c M. C. Wetherell, b Cowper	0
J. C. Wood, c Graham, b Cowper	0
C. A. Pitt, b Trubshaw	13
W. Young, c Barber, b Poyser	23
C. R. Stampe, c Brydone, b M. C. Wetherell	23
K. Johnstone, b M. C. Wetherell	2
G. I. Johnstone, not out	1
Bland, b Trubshaw	0
Extras	19
Total	127

2nd Innings.

C. H. Hunter, c Cowper, b Brydone	20
F. D. Logan, not out	31
G. I. Johnstone, not out	11
Extras	3
Total (2 wickets)	65

GUY'S.

F. C. Wetherell, b J. C. Wood	7
J. M. Brydone, b Pitt	29
E. A. Collins, run out	1
R. C. Poyser, b Haywood	15
H. Barber, lbw, b Haywood	55
K. V. Trubshaw, b Haywood	0
A. S. Graham, c Stampe, b Haywood	0
M. C. Wetherell, lbw, b Haywood	7
H. Morres, c & b Haywood	0
S. C. Bowle, b Haywood	18
C. M. L. Cowper, not out	1
Extras	12
Total	145

GUY'S v. WALDEGRAVE PARK.

Played at Honor Oak on Saturday the 9th, resulted in a draw. Guy's went in first and realized 333 for 7 wickets; F. C. Wetherell making 107, and Morres 62. Our opponents replied with 189 for 5 wickets, of which total H. E. Scoones played exceedingly well for 106. Score:—

GUY'S.

J. M. Brydone, b Walbanck	36
F. C. Wetherell, b Trew	107
R. C. Poyser, c & b Walbanck	0
H. Barber, lbw, b Lidbetter	1
F. Morres, c Sub, b Trew	62
K. V. Trubshaw, not out	37
G. S. Graham-Smith, c O'Neill, b Walbanck	32
M. C. Wetherell, b Stanger-Leathes	10
Extras	48
Total	333

S. C. Bowle, H. Edey, C. M. L. Cowper did not bat.

WALDEGRAVE PARK.

T. O'Neill, b Cowper	0
H. E. Scoones, not out	106
W. Walbanck, b M. C. Wetherell	23
Lidbetter, run out	3
H. C. Boyle, b Poyser	6
S. C. S. Leathes, b M. C. Wetherell	16
H. C. S. Leathes, not out	9
Extras	26
Total	189

GUY'S 1st XI. v. HORNSEY.

This match was played at Hornsey on Wednesday, June 13th. Our opponents won the toss and made 208; Guy's replied with 179 for five wickets, J. M. Brydone making 53 in the very best form. Score:—

A. E. Nicholls, b Higgs	18
F. G. Nicholls, c Higgs, b Trubshaw	41
F. B. Dent, lbw, b Morres	50
H. M. Barker, b Trubshaw	18
F. H. Swinstead, c & b F. C. Wetherell	1
C. M. Skinner, c Higgs, b F. C. Wetherell	11
S. L. King, b F. C. Wetherell	0
H. A. Nicholls, not out	34
T. W. Sloper, run out	5
R. C. K. Johnson, b Morres	4
P. Bromfield, b Mores	5
Extras	21
Total	208

GUY'S.

F. C. Wetherell, b Skinner	23
J. M. Brydone, b Swinstead	53
H. Morres, b Swinstead	5
H. Barber, c Bromfield, b A. E. Nicholls	31
K. V. Trubshaw, not out	33
G. S. Graham-Smith, b Swinstead	18
Extras	16
Total	179

M. C. Wetherell, T. Morgan, J. T. Hicks did not bat.

PAST v. PRESENT.

This match was played at Honor Oak on June 15th; was won by the Present by 101 runs.

Lucas made 76 not out for the Past, and Barber took 115 of the best for the Present. After the match Mr. Brailey entertained both teams, the residents, and representatives of the various athletic clubs to dinner at the College, where a most enjoyable evening was spent. Score:—

PAST.

E. A. Clarke, b Edey	6
W. I. Hancock, c Barber, b Trubshaw	34
C. H. Fagge, b M. C. Wetherell	1
A. Lucas, not out	76
N. Lavers, c Brydone, b Edey	8
R. Bryden, b Trubshaw	0
J. Barker, b Trubshaw	0
A. E. Causton, b Cowper	11
F. D. S. Jackson b Edey	5
T. Morgan, c Hicks, b Cowper	9
H. Durbridge, b Edey	0
Extras	28
Total	178

PRESENT.

J. M. Brydone, b Hancock	1
F. C. Wetherell, run out	41
F. Morres, b Hancock	2
H. Barber, c & b Hancock	115
K. V. Trubshaw, c Clarke, b Lavers	32
M. C. Wetherell, b Lavers	10
H. M. Langdale, b Lucas	20
R. C. Poyser, b Lucas	8
J. H. Edey, lbw, b Hancock	0
J. T. Hicks, c Causton, b Lucas	28
C. M. S. Cowper, not out	6
Extras	16
Total	279

GUY'S 2ND XI. v. CROYDON 2ND XI.

(WON BY 18 RUNS).

Played at Croydon on Saturday, June 9th. The feature of the game was a brilliant contribution of 53 by Morgan. Score:—

GUY'S.

E. Morgan, st Bush, b Long	53
E. A. Collins, c Butler, b Drage	9
A. H. Turner, lbw, b Watson	10
A. M. Tollhurst, st Bush, b Watson	5
W. H. Bush, b Butler	5
T. P. Thomas, lbw, b Long	0
J. T. Hicks, c Roberts, b Butler	18
E. W. Strange, c Watson, b Butler	1
R. D. Bridger, not out	8
F. C. Robinson, c Archer, b Drage	0
T. A. Chignell, b Butler	1
Extras	15
Total	125

CROYDON.

C. Woolcott, c Strange, b Chignell	3
G. F. Long, c Strange, b Chignell	9
M. W. Robins, c Thomas, b Chignell	4
C. H. Richer, b Hicks	14
R. Archer, c Hicks, b Chignell	21
C. P. Wicks, b Hicks	22
V. G. Butler, b Hicks	4
A. S. Bush, b Chignell	0
A. E. Drage, lbw, b Chignell	10
D. Roberts, b Hicks	0
L. R. Watson, not out	0
Extras	20
Total	107

HOS.-SCHO. C. C. v. PARK C. C.

Played at Sydenham, June 9th. Hos.-Scho., 23; Park, 86.

HOS.-SCHO. C. C. v. ST. GEORGE'S, CAMBERWELL.

Played at Brockley, June 16th. Hos.-Scho., 99 for 9 wickets; St. George's, 24. Crowdey took 6 wickets for 12 runs, and Hussey 3 for 10. Crowdey made 22 runs, Woods, 14, Hussey, 15 not out.

Guy's Hospital Lawn Tennis Club.

GUY'S v. REDHILL.

Played at Redhill on Saturday, June 9th, and resulted in a win for the home team by 9 events to 0. We were a weak team being without our Captain and L. Cooke.

H. Wacher and E. N. Jupp lost to H. B. Childs and H. T. Childs, 3-6, 5-7; lost to E. Burtt and A. W. Makovski, 0-6, 1-6; lost to J. Powell and W. J. Down, 1-6, 1-6. B. H. Wedd and C. D. Pye-Smith lost to H. B. Childs and H. T. Childs, 3-6, 2-6; lost to E. Burtt and A. W. Makovski, 0-6, 2-6; lost to J. Powell and W. T. Down, 2-6, 0-6. H. Bacon and J. S. Steele-Perkins, lost to H. B. Childs and H. T. Childs, 2-6, 2-6; lost to E. Burtt and A. W. Makovski, 4-6, 2-6; lost to J. Powell and W. J. Down, 2-6, 6-4, 1-6.

GUY'S v. BART.'S.—INTER-HOSPITAL CUP TIE.

In the Cup match which took place at Chiswick Park on Thursday, June 14th, we were again defeated by Bart.'s, the winners of the Inter-Hospital Cup.

We only secured one set in the Singles, which was won by B. H. Wedd.

In the Doubles we were all beaten, and not one of our couples was able to win even a set in their matches.

PAST v. PRESENT.

The annual match between the Past and Present students was played at Honor Oak Park on Saturday, June 16th, and resulted in a win for the Past by 11 matches to 4.

Dr. Goodall again captained the Past team, and brought down a very strong side, including some well-known players.

In the Singles, H. Wacher and L. Cooke won their matches.

In the Doubles our first and second couples won v. the third couple.

The Past team turned up one short, so J. S. Steele-Perkins played for them. Score:—

SINGLES.—E. N. Jupp lost to S. Rivers, 0-6, 1-6. B. H. Wedd lost to H. G. Biddle, 4-6, 0-6. H. K. Lacey lost to T. Fisher, 1-6, 4-6. H. Bacon lost to E. W. Goodall, 7-5, 4-6, 5-7. L. Cooke beat H. V. Hickman, 6-4, 4-6, 6-2. H. Wacher beat J. S. Steele-Perkins (sub), 6-4, 3-6, 6-3.

DOUBLES.—Lacey and Jupp lost to Biddle and Fisher, 5-7, 0-6; lost to Rivers and Goodall, 1-6, 2-6; beat Hickman and Steele-Perkins, 6-4, 4-6, 6-1. Wedd and Bacon lost to Biddle and Fisher, 6-8, 2-6; lost to Rivers and Goodall, 1-6, 1-6; beat Hickman and Steele-Perkins, 8-6, 6-1. Wacher and Cooke lost to Biddle and Fisher, 3-6, 2-6; lost to Rivers and Goodall, 2-6, 1-6; lost to Hickman and Steele-Perkins 5-7, 3-6.

Guy's Hospital Football Club.

ASSOCIATION.

The following men have received their "Blue" for the last season's play:—S. P. Wadson, T. Edey, H. B. German, H. Barber, T. A. Chigwell.

H. Barber and N. P. Shepherd were awarded Honour Caps.

W. M. ROBSON, Hon. Sec.

Guy's Hospitals' Rifle Association.

U.H.R.A. v. UNITED ENGINEERING RIFLE CLUB.

The above match was shot at Runnemead on May 30th, and resulted in a win for the Hospitals by 41 points. Scores:—

	200	500	600	Total
C. de Z. Marshall (St. Thomas's) (Capt.)	29	28	24	81
G. Robinson (Guy's)	30	22	33	85
S. Hodgson (Guy's).....	24	27	28	79
G. R. Morris (St. Bartholomew's)	25	29	25	79
H. Upcott (St. Thomas's)	26	25	26	77
A. C. Brown (St. Bartholomew's)	25	23	24	72
O. B. Travers (Guy's)	21	24	24	69
J. F. Vaughan St. Thomas's) ...	23	26	19	68
	203	204	203	610

United Engineering Rifle Club, 569 points.

U.H.R.A. v. R.I.E.C.

This match was shot on the R.I.E.C. range at Cooper's Hill, on June 2nd, and resulted in a win for the R.I.E.C. by 50 points. Scores:—

R.I.E.C. 431 points.

U.H.R.A.	200	500	Total
C. de Z. Marshall (Capt.) (St. Thomas's)	27	28	55
C. M. Roberts (St. Thomas's)	24	28	52
S. Hodgson (Guy's).....	27	22	49
O. B. Travers (Guy's).....	26	23	49
J. F. Vaughan (St. Thomas's)	25	24	49
C. G. Seymour (St. Thomas's)	24	24	48
D. Finnegan (St. Bart.'s)	20	26	46
N. Maclaren (St. Bart.'s)	19	14	33
	192	189	381

Guy's Hospital Chess Club.

Result of Inter-Hospital Chess Competition:—

	Mary's.	London.	George's.	Bart's.	Middlx.	Guy's.	Univ'ty.	Total.	
Mary's ...	—	0	0	0	0	0	0	0	scrat'd.
London ...	1	—	0	1	1	½	1	4½	
George's ...	1	1	—	1	1	½	0	4½	
Bart's. ...	0	0	0	—	0	0	0	0	scrat'd.
Middlesex ...	0	0	0	0	—	0	0	0	"
Guy's ...	1	½	½	1	1	—	½	4½	
University ...	1	0	1	1	1	½	—	4½	

The shield is to be held for three months each by London, George's, University, and Guy's.

Papers by Guy's Men.

The Primary Disorders of Growth. By Hastings Gilford, F.R.C.S. Eng.—*Lancet*, 9th June.

Differentiation in Diabetes. By F. W. Pavy, M.D. Lond., LL.D. Glasg., F.R.S.—*Ibid.*, 16th June.

A Case of Strangulated Femoral Hernia in which Gangrene was Precipitated by an Intra-abdominal Volvulus. Illustrated. By R. Lawford Knaggs, M.C., F.R.C.S.—*Ibid.*

Notes on Gastro-Enteritis, Dysentery and Enteric Fever. By J. W. Washbourn.—*British Medical Journal*, 16th June.

Tubercular Disease of the Hip-Joint. Illustrated. By W. Arbuthnot Lane, M.S.—*Clinical Journal*, 20th June.

Births.

PAGET.—On June 5th, at Westbourne, Tenterden, Kent, the wife of Peter Paget, M.R.C.S., L.R.C.P. Lond., of a daughter.

YOUNG.—On June 7th, at 45, Stamford Hill, N., the wife of John Young, M.D., B.S., of a son.

Marriage.

FORTESCUE-BRICKDALE—WHITE.—On Thursday, June 14th, at St. John's Church, Notting Hill, W., by the Ven. Archdeacon of Middlesex, John Matthew, younger son of the late Matthew J. Fortescue-Brickdale, of Lincoln's Inn, to Edith Augustus, third daughter of George White, of Eltham, Kent.

SWAYNE—LYON.—On June 2nd, at All Saints', Upper Norwood, Francis Griffiths Swayne, of Church Road, Upper Norwood, to Etta Ellen, widow of G. R. Lyon, H.M.I.C.S., and third daughter of Warren Hastings D'Oyley, of Southsea and London.

Deaths.

BRYANT.—On June 7th, at Bloemfontein, South Africa, of enteric fever, Civil Surgeon H. A. Bryant, R.A.M.C.

EDWARDS.—On June 6th, at Felixstowe, George Cordy Edwards, M.R.C.S., late of Ipswich, in his 81st year.

FITZ-HUGH.—On June 16th, at Deelfontein, South Africa, of enteric fever, Richard Truman Fitz-Hugh, M.B. Lond., Civil Surgeon, Imperial Yeomanry.

HUGHES.—On June 11th, killed at Kroonstad, Lawson Jervis, Imperial Yeomanry Field Hospital, eldest son of Robert H. Hughes, M.A., M.B. Cantab., Plymouth, æt. 22.

JONES.—On June 18th, at Springfontein, South Africa, Thomas Jones, M.B., F.R.C.S., Professor of Surgery, Owens College, Manchester.

ED.—S. H.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well a subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

July, 1900.

Sat. 7.—Messrs. Lucas and Lane's take-in; Drs., A. W. Soper and W. M. Robson; Cl., T. J. Wright.
August Appointment List closed.
G.H.C.C., II., St. Bart.'s, away.
G.H.L.T.C., II., St. Bart.'s, home.
G.H.B.C., Run to Sevenoaks.

Mon. 9.—Second part of the Conjoint D.P.H. Exam. begins.
Preliminary Scientific M.B. Lond. Exam. begins.
1.15 p.m. Clinical lecture by Mr. Laidlaw Purvis.

Tues. 10.—G.H.S.C., Croydon Dolphin S.C., Croydon Baths.

Wed. 11.—1.30 p.m. Clinical lecture by Dr. Fawcett.

Thur. 12.—Messrs. Golding-Bird and Dunn's take-in; Drs., M. D. Wood and S. C. H. Bent; Cl., J. S. Steele-Perkins.

Sat. 14.—G.H.C.C., I., High Wycombe, away.
II., Hos.-Scho. C. C., home.
G.H.L.T.C., I., Harold, away.
II., Surbiton, away.
Hos-Scho. C.C., Guy's Students 2nd XI., home.
G.H.B.C., Run to Brighton.

Wed. 18.—1.30 p.m. Clinical lecture by Dr. Fawcett.
G.H.S.C., Tadpole S.C., St. George's Baths.

Thur. 19.—Messrs. Jacobson and Fripp's take-in; Drs., F. Curtis and G. S. Davidson; Cl., T. P. Thomas.

Sat. 21.—G.H.C.C., I., Kensington, away.
G.H.L.T.C., I., Dulwich Park, away.
G.H.B.C., Run to Leatherhead.
Hos.-Scho. C.C., Wandsworth Prison, away.

Guy's Hospital Gazette.

JULY 7, 1900.

Tetany.

CLINICAL LECTURE BY DR. FAWCETT.

May 2nd, 1900.

GENTLEMEN,—The case I propose to talk to you about to-day is one of "Tetany" occurring in a patient the subject of a gastric affection.

Tetany is rather a rare disease, although if you see much of children's diseases you are sure to meet with it a good many times. It is important for you to recognise, because, if severe, it is somewhat alarming in the suddenness of its onset, especially if the spasm is general; and it is a great comfort to your patients, or their parents, to be able to tell them that most cases eventually do well if they follow out your instructions, and that there is no immediate danger, alarming though the symptoms may be.

Our patient is a woman of thirty-nine, who was admitted with a history of "Hæmatemesis." She had had indigestion for four to five years, and for the last two years had had attacks of vomiting and pain after food. In August, 1899, she vomited blood for the first time. With regard to the vomiting, sometimes it occurred two hours after food, sometimes there was no vomiting for two or three days, and then a large quantity was brought up.

History of present attack.—The patient has been getting worse lately, and on April 7th, after eating some oysters, the vomiting became more severe. The symptoms continued to increase in severity, and on April 10th the patient said she vomited "about a pint of dark blood." The "hæmatemesis" continued for three days on and off. For the last few days cramp-like pain and tingling have been noticed in arms, hands, legs and feet. The patient was admitted late in the afternoon of April 14th, having been brought up to the hospital in a cab.

Condition on admission.—The patient is of sallow complexion, much emaciated and anæmic. She complained of pain in the epigastrium and there was tenderness in that region on palpation. The case was diagnosed as one of "gastric ulcer." There was no evidence of any dilatation of the stomach at that time.

At 9 p.m. on this day she was seized with tingling pains in the feet, hands, and abdomen; she also had difficulty in speaking and breathing. Shortly after the hands became rigid, the

thumbs flexed at the metacarpo-phalangeal joint and strongly adducted, the tips of them touching the base of the little finger. The fingers were flexed at the metacarpo-phalangeal joint, extended at the inter-phalangeal joint, and firmly adducted, so that finally the fingers were crowded together, giving to the hand a conical shape, the "accoucheur's hand."

The wrists and elbows were strongly flexed, and the forearms adducted to the sides. The legs became extended, the feet being in a position of "talipes equino-varus," the dorsum of feet arched, and the toes adducted. The abdominal muscles were rigid, the outlines of the "recti" being well defined. The "masseters" were slightly contracted and the corners of the mouth drawn up and out when the mouth was opened, thus giving rise to a distinct grin. There was no contraction of any other muscle, but the patient had distinct difficulty in speaking. The facial muscles contracted sharply on percussion over them. The spasm passed off in a quarter of an hour, but the feelings of numbness and stiffness remained till the next morning.

Up to the present the patient has had no recurrence of the attack. There has been no more "hæmatemesis," but since the patient has been fed by the mouth the signs of "dilatation of the stomach" have become manifest. Here, then, we have an example of a mild, but none the less very typical case, of "tetany" in an adult, in which the spasm affected the muscles of the limbs, abdomen and face.

A considerable number of the symptoms of the disease were present, but others which were not I intend to draw your attention to by reference to the twelve cases which have been in the hospital from 1888 up to the present time. The *characteristic features of the disease* are that it consists of tonic muscular spasms of a peculiar type, involving chiefly the distal portions of the limbs, and that these spasms are generally symmetrical in their distribution.

These features we saw in the case I have described to you. The spasm, however, varies a good deal in different cases. It may be remittent, intermittent, or continuous, and very different gradations of it exist, from the slight "carpo-pedal" contractions to severe general spasm.

Ætiology.—If we look into the conditions under which, or in association with which, tetany occurs, we find it is commonest in children, in infants, and young adults, that is up to the second decade. Up to this age males are more often affected than females, but afterwards the incidence is chiefly upon females. Our patient is a woman of thirty-nine.

1. The most common exciting cause is some affection of the alimentary canal, *e.g.* (*a*) a chronic diarrhœa, (*b*) a dilated stomach. It has been found also in association with gastric disorder of other kinds, with catarrhal jaundice, and with the presence of worms in the intestines.

2. It is met with in pregnancy, in the period of lactation, or that of the puerperium, or with diseases of the female generative organ.

3. After thyroidectomy in man or animals.

4. As a sequelæ of some of the acute infectious diseases, as small-pox, or typhoid, &c.

5. Sometimes in an epidemic form.

6. It has also been met with under many other conditions, *e.g.*, with albuminuria, alcoholic and lead poisoning, and with some diseases of the nervous system, *e.g.*, epilepsy.

7. Rickets is the disease in children with which tetany is especially connected, and with it vomiting and diarrhœa are the exciting causes.

The most important *predisposing causes* are *cold*, and *fatigue* in whatever way produced.

I thought that in our case, probably, both these factors were concerned in originating the attacks. We have a woman who, to start with, is enfeebled by her chronic dyspepsia, who is rendered still more so by the attack of hæmatemesis, and who is also the subject of a dilated stomach.

The exertion caused by bringing her up to the hospital in a cab was "the last straw," and the attack I have told you of, the result.

Attack.—With regard to the clinical features of the attack I wish to draw your attention again to the description I have already read, and which is made from the careful notes of Mr. Moss. The position described is quite characteristic, the conical hand, the flexion at the metacarpo-phalangeal joints, the extension of the inter-phalangeal joints, the flexion of the wrists and elbows, and the adduction of the arms to the sides.

In the lower extremities the slightly inverted position of the feet, which are in the position of "talipes equino-varus."

Then, too, we saw that the trunk muscles were affected, and when that is so it is almost always those on the ventral surface. In our case it was the anterior abdominal muscles, and it was especially noted that the outlines of the recti were well defined.

It is a rare thing for the spasm to affect the dorsal muscles and to cause opisthotones, but it does sometimes occur, and I shall presently relate to you an instance of this.

There was also some "trismus" in this case, but it is not often seen in such mild cases.

The tongue, laryngeal and pharyngeal muscles may be affected, rendering speech difficult and perhaps giving rise to laryngeal spasm.

There was difficulty in speaking in this case during the attack.

The neck muscles are sometimes contracted, the "sterno-mastoids" the most frequently, so that the head is bent down towards, or upon, the "sternum."

The spasm of the facial muscles generally occurs in severe cases, but it may happen in mild ones, as in this case.

The spasms themselves are generally paroxysmal. They may continue over a space of a few minutes, an hour, a few days, or several months.

The muscular contraction commonly passes off to recur again in a day or two. In some the spasm never wholly disappears. It persists in a less marked form in the arms and legs, and becomes more marked again at intervals.

Slight spasm occurs comparatively frequently during sleep, and this is specially seen in women whose general condition of heath is bad.

Sometimes it persists during sleep, although generally lessened at this time. I shall, however, later on bring to your notice a case in which there was no alteration during this period.

The contracted muscles are hard, and to overcome them a very considerable amount of force is necessary. The spasm, even then, generally recurs very soon.

After the attack has passed off, sensations of tingling, of stiffness of muscles, or of tenderness on pressure, persist, as we saw in the case I have related to you.

In the intervals of an attack any muscular effort may bring on another spasm; and in cases of dilated stomach the washing out of that organ may do so.

An attack may also be evoked by compression of the affected limb, by pressure on the nerve and artery. This fact was first pointed out by Trousseau. We did not try it in our case, but it is a very characteristic feature of the disease.

Another most important sign is the *increased excitability of the muscles and nerves* which exists.

It was well shown in our patient. Demonstration of it is made by percussion over the muscle, or the motor nerve to the muscle.

It is seen more often in the face than elsewhere, although it may be present in any of the muscles.

But not only is the mechanical excitability of the nerves and muscles increased but *their electrical excitability* also.

The nerves are more susceptible than usual to both the interrupted and constant currents, and there is also a change in the polar reactions.

The positive pole more readily produces a contraction, either when the current is made, or broken, than does the negative pole when the current is made. The contraction produced, too, is a *larger one*.

Thus, then, our order of contraction in cases of tetany is usually (i.) A.C.C. or A.O.C.; (ii.) K.C.C.

This, however, you must remember, is *not invariable*.

It is found, too, that all nerves are not equally excitable, and generally the *ulnar nerve* shows this increase of excitability better than any other.

It is a curious fact that the facial nerve, although so excitable to mechanical, is very little so to electrical stimuli.

The next class of important symptoms are *the sensory ones*. In the case before you, you may remember that these were present both before and after the onset of the muscular spasms, and that is the usual history. They consisted of "tingling and cramp-like pains," of "numbness," and stiffness, and they persisted for some hours after the attack. The sensory symptoms are generally well-marked and the cramp-like pain in muscles often severe. It was especially so in one of the cases I shall refer to later. Direct pressure made over the muscles, nerves or joints is often also painful, and the symptoms that have been noted in different cases are those of heat and cold, of pins and needles, and so on; but, just as in the case of the muscular spasm, the distribution, variety, and severity, of the sensory symptoms vary greatly.

Vaso-motor and trophic disturbances occur, but for examples of them I must refer you to the list of cases. Œdema of the hands and feet is the most common and it is especially in children that it occurs. That was so in Case 11.

Other vaso-motor phenomenon recorded are flushing of the face, injection of the eyes, and redness of the ears, sweating and dryness of the skin, cyanosis of the extremities, or even gangrene in feeble emaciated children.

Skin eruptions, too, of an erythematous, urticarial, scarlatiniform and morbilliform type have been seen.

Pyrexia is sometimes present, especially in severe cases (*vide* Case 2), and pulse and respiration rate may be quickened.

Polyuria, albuminuria, mucosuria, glycosuria and indicanuria, the latter more often in children, are also described as being present in some cases, but I have no case in which any of these conditions were present.

There have been thirteen cases of tetany in the hospital since 1888, of which I have notes of twelve.

CASE 1.—Ethel F., æt. 25, under Dr. Shaw in Miriam, 1898, and in 1897 she was under Dr. Pye-Smith. Patient had had the right and middle lobe of the thyroid removed by Mr. Howse in 1893, and in September, 1897, the remaining lobe, except for a small portion, was excised.

On the day after this operation some twitching of the hands was noticed, and at intervals of two to three days painful cramps ensued. These continued after discharge, and up till November, 1897 patient had had about twelve attacks.

In May, 1897, when under Dr. Pye-Smith, a typical tetany spasm occurred on the day of admission, and on the third, sixth, seventh and ninth day. Then there was an interval of fourteen days.

After treatment by thyroid extract the attacks diminished very much, consisting only of occasional spasm of the thumb muscles lasting a few hours, and twitchings of muscles. The longest attack lasted for twelve hours and a half. Chvostek's and Trousseau's signs were present.

The case is an excellent example of tetany, of intermittent form, following thyriodectomy, and instances also the value of the thyroid treatment.

CASE 2.—Ivy H., æt. 5, under Dr. Shaw in Miriam, 1896. The child had always been delicate. She has had "any sort of diet." Since an attack of measles at two years old has suffered with chronic diarrhœa.

On admission—Was a feeble, sickly child.

The spasm was characteristic. It came on quite suddenly, and as the mother described it, "she screwed in her little thumbs and pointed her fingers."

Both hands, forearms, feet and toes, were affected in the typical way.

The child rapidly recovered on proper feeding, meat-juice, gravy, and peptonized milk to start with, and Ol. Morrhuæ.

The case is a good example of a mild variety of tetany occurring in a child with rickets, the subject of a chronic diarrhœa; conditions which I told you previously were the most favourable ones for the development of the disease in children.

CASE 3.—Ada C., æt. 7, Dr. Washbourn, 1894.

The spasms in this case came on after an attack of diphtheria for which the child was in a fever hospital for seven weeks.

The child was an anæmic excitable girl.

The attacks occurred once a day over a course of three days. After this they did not recur.

The case is, then, an example of tetany following one of the acute infectious diseases.

CASE 4.—Eliza S., æt. 3, Clinical, 1891. No report.

CASE 5.—Christ. S., æt. 18, 1890.

The patient was the subject of a lardaceous disease, and on admission was suffering with diarrhœa and sickness.

The latter continued, and a week after admission the patient had a typical attack of tetany. The details given in report are very meagre, and there is no statement as to the duration or variety of the attack.

The patient's general condition was a "low level" one, and he was the subject of chronic gastro-intestinal and visceral disease.

CASE 6.—Nettie P., æt. 31, under Dr. Taylor, 1890. The history states that the attack occurred a few days after the last confinement, and directly after washing the hands in cold water.

The attacks consisted in formications followed by spasms in thumb muscle. Also paræsthesial in lower extremities.

During three months there were several seizures. They lasted about 5–10 minutes.

Two or three attacks generally quickly followed one another and then there was immunity for a week.

Here we have as the predisposing cause the occurrence of a recent confinement, and as the exciting one the dipping of the hands into cold water, both of which factors I have already drawn your attention to in considering the ætiology of the disease.

The sensory symptoms were a marked feature.

CASE 7.—John H., æt. 7, under Dr. Pye-Smith, 1889. One of his brothers had died of tetany nine weeks before admission.

Patient was admitted on November 14th. The cramped condition of fingers and thumb had been noticed two days previously, and he also complained of slight pain in the ear.

He is stated not to have looked well for some weeks. He had been constipated, irritable, and restless.

The boy is described as healthy looking and intelligent, with no signs of rickets. He had mitral regurgitation.

Shortly after admission he had two attacks, one about an hour after the other. The attacks

lasted about five to ten minutes. The pain was a marked feature, being sufficiently severe to make the boy cry.

There was no increase of electrical excitability nor did pressure on the sciatic nerve or femoral artery produce any spasm.

The boy had frequent attacks, which gradually became less frequent, and on December 6th the last occurred. He went out quite well.

He was treated with Pot. Bromidi, and massage for the pain.

CASE 8.—Leighton M., æt. 4, under Dr. Taylor. Admitted for sickness, and pain and stiffness in the legs and arms. He has had occasional bilious attacks followed by vomiting, which leave him very weak.

On April 20th, he complained of pain after his dinner and soon after was sick. Then he began to complain of the legs hurting him, and was sick seven or eight times during the night.

In morning he could not stand; "legs were stiff, feet drawn in and tender, and hands also turned." He could not bear to have his legs touched."

The boy had signs of rickets, viz., curved tibiæ and bosses over the costo-chondral junctions.

The spasm was of the typical variety. It disappeared twenty-four hours after admission and he went out quite well.

He was treated with Chloral Hyd., Pot. Brom., and Pulv. Rhei. Co.

CASE 9.—Ada T., æt. 6, under Dr. Wooldridge, 1888. She was in the hospital early in 1887, under Dr. Goodhart, with "gastro-enteritis," and again in October of that year with "wasting and diarrhœa." There was no signs of rickets present

Patient had some diarrhœa. There was some slight œdema of arms, and of the legs as high as the knees, and also ascites, but no albuminuria.

She was admitted on August 24th, and on August 27th, diarrhœa is noted as still being present.

On August 30th, a typical attack of tetany developed. The child complained of a good deal of pain especially in the hands, and extension of the joints caused much pain. The skin was hot.

August 31st. A recurrence of the spasm occurred.

September 6th. Diarrhœa noted as being still present.

Patient ultimately got quite well.

Again, the condition is associated with gastro-intestinal disturbance, and the pain was noted as being marked.

CASE 10.—Amy B., æt. 4, in Clinical, 1890. There was a previous history of stomatitis and child was markedly rachitic.

Spasms came on in feet and legs first, coincident with attack of diarrhœa.

The hands, wrists, elbows and knees were later affected.

As the stomatitis cleared up the spasms disappeared.

CASE 11.—Leonard H., æt. 5, under Dr. Pye-Smith, August. The boy was admitted with pains in the legs and diarrhœa. "Worms" were said to be present in the fæces.

He had typical spasm of all four limbs. Chvostek's sign, on tapping the facial nerve, was well-marked. The abdominal muscles were firmly contracted.

There was pain on movement of the knee-joints and those of the hands and feet.

The temperature varied between 97·4° and 102°.

The head and face sweated profusely and there was also œdema of the hands.

Attempts to overcome the spasm gave rise to considerable pain. Another interesting feature of the case was that the spasm did not relax during sleep.

This condition persisted, more or less marked, until August 28th, when the muscles of the back and abdomen also became rigid.

On September 2nd slight facial spasm was noted.

The administration of $CHCl_3$ produced hardly any relaxation of the spasm.

This patient died, and no changes were found in the central nervous system.

This case was a very severe one of the "continuous" type, in which both ventral and dorsal trunk muscles were involved.

The patient had an irregular temperature and also showed vaso-motor and trophic phenomena.

CASE 12.—Julia F., æt. 34, under Dr. Pitt. She was admitted in March, 1900, for vomiting and weakness. There was a history of hæmatemesis during the last year. On March 17th had "a drawn feeling in her legs and arms." The attack lasted six hours.

Condition on admission.—Signs of phthisis in left lung. The liver and spleen were enlarged. The stomach was dilated. There was some hæmatemesis on April 11th and vomiting. She had an attack of tetany in her right hand, preceded by pain in the stomach and giddiness. For some days before her hand had felt numb.

A doubtful case, but it is described as one of tetany, and in the case we have one of the

common predisposing conditions, viz., a dilated stomach with signs of ulcer present.

Pathology.

1. *Where is the disease located :*—The muscles, peripheral nerves, the spinal cord, anterior cornual cells, and the medulla, have all been thought at different times to be the seat of the disease.

Hyperæmia of brain, capillary hæmorrhages and perivascular lymphoid exudation. Shrunken and vacuolated anterior cornual cells, atrophy of nerve fibres and increase of neurologial tissues have been described as associated microscopical changes. On the other hand, there are cases recorded as in case No. 11 of our series, where the brain and spinal cord were examined and no pathological changes found.

The cord, brain, peripheral nerves and muscles have also been examined by several observers and found quite normal.

The most definite of all the above changes appear to have been those found in the anterior cornual cells.

Now let us consider for a moment which of these positions is most probably affected in tetany. Let us take a diagrammatic representation of the motor tract and consider the general symptoms associated with disease of the different parts. In favour of the *cerebral* origin of tetany we may point to the interosseous spasm, somewhat like that seen in congenital spastic paraplegia, and to the association with convulsions in children, but the position of the hand is not the same as in cerebral diplegias, and the convulsions and tetanic attack are not sychronous in their course, the convulsions being only an addition to the main disease.

The symptoms are not in any way like those associated with degeneration in the *pyramidal tracts* in the cord, because, although there is spasm, it is of a peculiar type, and there is no exaggeration of reflex and jerks as in lateral tract disease.

Again, although the changes in the *anterior cornual cells* are the most definite that have been recorded, and although rarely atrophy of muscles does follow tetany we do not recognize spasm as a part of disease of the anterior cornual cells. It is possible that a poison is the cause of the disease, and that it acts on the cornual cells as strychnine is said to do. The way in which strychnine acts, however, is doubtful. On the whole, it seems to me that the view of the *peripheral nerves* being the chief seat of the disease, is by far the most likely, and in favour of this are :—

i. Its symmetrical peripheral distribution.

ii. The sensory phenomena.

iii. The increased excitability of the muscles and nerves to mechanical and electrical stimuli.

2. *How are the nerves acted on ?*—Probably by a poison circulating in the body, just as in the case of alcoholic paralysis.

In this connection we have two very prominent facts, of both of which and their connection with the disease, I have cited examples.

1. Take first Case 1, which followed thyroidectomy. You may remember that Schiff showed that complete thyroidectomy in dogs was followed by tremors, spasms, and convulsive attacks, "tetany"; and Horsley that in monkeys myxœdematous symptoms developed in addition.

We suppose nowadays that the thyroid possesses an internal secretion, and we explain phenomena resulting from its removal by the absence of a secretion which is essential for the proper carrying out of some of the metabolic processes in the body.

That this is true is proved by the beneficial effects of its administration to myxœdematous patients.

The secretion, it is also suggested, may possess the function of destroying poisonous metabolic products, but of this there is no proof at present.

Horsley suggested that there was actually some poison formed in these cases, and it is very interesting to note that a body named "thyro-protein" has been separated out from the thyroid by Notkin, and this body is said to produce in animals symptoms resembling those of tetany.

Another body, "thyro-antitoxin," isolated by Franckel, is said to be capable of neutralising the spasms.

2. The second interesting point in this connection is that the disease is so commonly associated with affections of the alimentary canal. In children rickets and gastro-intestinal disturbance are, as I have pointed out to you in the list of cases, almost always present, and in adults some gastric affection, and especially dilatation of the stomach.

Now, toxic bodies have been isolated from the stomach in these cases, which, when injected into animals, cause convulsions, and an alkaloid has been found in the vomit and in the urine by Ewald and Jacobson.

3. Certain poisons are capable of producing symptoms like tetany, such as ergot.

4. In lactation, the puerperal period, and during pregnancy, metabolism is increased and the thyroid has more work to do in counteracting this. We know the thyroid often enlarges in pregnancy, and Halstead has shown that in

dogs tetany does not occur after a partial removal of the thyroid unless the dog be pregnant.

5. Fatigue, again, is associated with increased metabolism, and the accumulation of waste products and highly poisonous substances have been found in the urine after severe exertion.

Thus, then, taking all the above into consideration the most likely explanation of the tetany attacks is that we have some poison circulating through the body which acts upon the central nervous system, probably chiefly through the peripheral nerves.

That it is possibly an infectious disease is suggested by the epidemics of it which have been recorded.

Diagnosis.—The most important points here are its *onset in the extremities*, its restriction to certain groups of muscles, and its symmetry.

The intermission of the attacks, and reproduction voluntarily by pressure on main nerve trunks is also characteristic, and with the above we have the increased mechanical and electrical excitability.

The early sensory phenomena and those that persist afterwards, are very common features.

Tetanus.—If the attack of tetany be a very severe one it may be difficult to decide, but as a rule, by careful observation of the case, and attention to its history, it is easy.

The spasm of the masseters is the one of the latest phenomena in tetany, whereas it is the earliest in tetanus.

Again, the early affection of the fingers and hands is extremely characteristic. In tetany also we see that it is chiefly the adductors, internal rotators and reflexors which are affected, whereas in "tetanus" it is the opposite.

In the *tetanus of new born children* there is their age, there is the channel of infection, the umbilicus, and trismus is well marked.

The only other diseases possible to confound with tetany are (1) cerebro spinal meningitis, (2) hysterical contracture.

In (1) the pain running along the course of the nerves, the pyrexia, and the persistence of the spasm, are the chief symptoms pointing to a spinal meningitis. Later, too, the affected parts become paralysed.

In (2) hysterical contracture the spasm is generally one sided. The special symptoms of tetany are not present and there is other evidence of hysteria.

Tubercular meningitis, epilepsy, and infantile diplegias, are mentioned as diseases with which tetany might be confounded.

Prognosis is generally a favourable one, except after thyroidectomy, or with dilated stomach.

In very young children, especially if laryngeal spasms, or convulsions ensue, the prognosis is bad. Here, however, the children are generally much enfeebled by a chronic or severe diarrhœa.

Treatment.—As regards the treatment, a single dose of potassium bromide was sufficient for our patient, and it is generally found that this drug will relieve the spasm.

The principle to go on is, of course, to remove the cause if possible.

In rachitic children with gastro-intestinal disturbance, to remedy their diet—to substitute for the parents "Oh, he has anything we have," proper milk feeding with cream, meat-juice, or albumen water, and so on. To regulate the bowels and to give later such drugs as Ol. Morrhuæ, Maltine, etc.

At the same time it is most important afterwards to do everything possible to prevent the recurrence of the attacks by attention to their general health, proper bathing, proper clothes, sufficient fresh air, etc.

After thyroidectomy, extract of thyroid gland must be administered. It is discouraging, however, to learn that although so valuable in these cases it is not so in those arising from other causes.

In cases associated with dilated stomach the organ may be washed out with warm water with some antiseptic in it.

Anthelmintics must be administered if worms be present.

It is equally important in adults, as in children, to attend to the diet, to remove all exhausting influences, *e.g.*, to check chronic diarrhœa, and to administer drugs such as Ol. Morrhuæ, Arsenic, etc., which will improve the general nutrition.

In the treatment of the spasm, Bromide and Chloral are the most useful drugs. They can always be given by the rectum if spasm is produced by trying to swallow. Pot. Brom. ʒss. t.d.s. will generally relieve the spasm.

The painful contractures may be considerably relieved by the external application of stimulating liniments, such as Lin. Chloroformi and Belladonna. Cold applications, as ice to the spine, are recommended by Trousseau. $CHCl_3$ may be necessary if the spasm cannot be relieved in other ways, but it must be very carefully administered as it may at first increase the spasm.

If cold be the exciting cause then warm baths and free diaphoresis are useful. Gowers states that for nocturnal tetany there is nothing so useful as a dose of Digitalis at bedtime.

DR. FAWCETT ON TETANY.—TABLE OF CASES.

Case.	Name.	Age.	Ætiology.	Type.	Chvostek's Sign.	Trousseau's Sign.
1	Ethel F. ...	25	Thyroidectomy	Intermittent and mild	Present	Present
2	Ivy H. ...	5	Rickets. Chronic diarrhœa	Intermittent and mild	—	—
3	Ada C. ...	7	Following Diphtheria	Intermittent and mild	—	—
5	Christ. S. ..	18	Lardaceous disease with chronic diarrhœa and vomiting	— ...	—	—
6	Nettie P. ...	31	The puerperal period. Cold	Mild	—	—
7	John H. ...	7	? Mitral regurgitation	Moderate	—	—
8	Leighton Mc.	4	Gastro-intestinal disturbance. Rickets	Mild	—	—
9	Ada T. ...	6	Chronic gastro-intestinal disturbance ...	Mild	—	—
10	Amy B. ..	4	Diarrhœa, stomatitis and rickets ...	Mild	—	—
11	Leonard H. ...	11	Diarrhœa	Severe and continuous. Death	Present	Present
12	Julia F. ...	34	Dilated stomach	Mild	—	—
13	— ...	39	Dilated stomach. Gastric ulcer ...	Mild	Present	—

Guy's Hospital Clubs' Union.

ANNUAL REPORT AND BALANCE SHEET, 1899–1900.

The Council of the Clubs' Union have much pleasure in presenting the Eighth Annual Report of the progress of the Union, together with a statement of the Receipts and Expenditure for the year ending March 31st, 1900.

The number of members of the Union continues to show a steady increase, the increase this year being 94, as against 72 last year; the present total membership is 2,047, of whom 1,888 are life members, 121 subscribing members, and 38 patrons.

The continued support accorded by the Governors and Consulting and Active Staff, and old Guy's men, is most gratifying to the Council; the number of Patrons (whose names appear on the first page of the Blue Book) having increased from 33 to 38.

We again venture to point out to old Guy's men who have not paid their guinea subscription for life membership, the advantages of having their names and addresses in the Clubs Union Blue Book, which is a useful directory, and is much used by members who wish their patients when away from home to be looked after by Guy's men.

During last winter, Harris, the groundman, has levelled and relaid the whole of the cricket pitch. The whole of the terrace has also been not only levelled and relaid, but a large amount of good mould has been put down under the turf. This should be of great benefit in lessening the hardness and rapid wear of the tennis courts on the terrace. This season three more tennis courts have been opened in front of the pavilion. It is hoped that by doing this it will be possible to rest three courts at a time, and so keep the whole number in a better condition than has been possible heretofore. The annual meeting of the Athletic Club was again held on the Clubs' Union ground last year, and will also be held there this year.

The best thanks of the Council are due to the officers of the Constituent Institutions, to the Auditors, and to Mr. Croucher and the other members of the School Office Staff for their able assistance.

The net income for the year, deducting balance from last year, amounts to £1,755 8s. 1d. Last year the net income was £1,881 11s. 3d. The diminution in income of £126 3s. 2d. is mainly due to two causes, the amounts received from subscriptions and donations being £98 18s. 6d. less than last year, and the gate money having dropped by nearly one-half. The exercise of more care in the arrangement of football matches during the ensuing season will, it is hoped, result in a substantial increase in the gate money.

The total expenditure this year, it will be seen, amounts to £2,248 8s. 1d., an increase of £144 16s. 4d. on last year. The debt of the Union, however, has been diminished to the extent of £200, so that the true expenditure due to working expenses has really resulted in an actual saving of £55 3s. 8d. on the year.

Statement of Receipts and Expenditure from 1st April, 1899, to 31st March, 1900.

1899. RECEIPTS.	£ s. d.	£ s. d.
April 1st.		
To Balance at Bankers... ...	490 16 3	
„ Petty Cash in hand... ...	2 3 9	
		493 0 0
Aug. 31st.		
To Subscriptions and Donations from April 1st to August 31st, 1899	323 6 0	
1900.		
March 31st.		
To Subscriptions and Donations from September 1st, 1899, to March 31st, 1900 ...	1078 16 6	
		1402 2 6
„ Grant from Medical School		100 0 0
„ Grant from Dental School		15 0 0
„ Rent from Tenants		75 0 0
„ Rent from U.H.C.C.		5 5 0
„ Rent from Lockers		11 10 0
„ Gate Receipts		9 17 9
„ Blue Book Advertisements		69 19 6
„ Sale of Railway Tickets		66 13 4
		£2,248 8 1

1900. EXPENDITURE.	£ s. d.	£ s. d.
March 31st.		
By Grants to Constituent Institutions—		
Athletic Club	30 0 5	
Bicycle Club	6 17 0	
Christian Union	3 5 6	
Cricket Club	16 7 3	
Dental Society	9 11 7	
Football Club, Association	13 6 3	
Football Club, Rugby ...	26 0 9	
Guy's Hospital Gazette ...	299 5 0	
Guy's Hospital Reports ...	234 0 0	
Physical Society (2 years)...	48 0 0	
Students' Club	291 0 1	
Swimming Club	3 0 11	
Lawn Tennis Club... ...	11 11 9	
		992 6 6
„ Field current expenses ...	214 1 3	
„ Field Rent Account (Interest on Loan)	234 10 0	
		448 11 3
„ Management Expenses—		
Printing and Stationery ...	8 19 1	
Secretarial Expenses ...	43 17 8	
Postages	3 9 0	
Insurance	1 7 0	
Production of Year Book...	84 9 10	
		142 2 7
„ Railway Ticket Deposit Account ...		66 13 4
„ Rates and Taxes		43 13 5
„ Petty Cash Expenditure		1 3 6
„ Amalgamated Clubs' Account (Repayment of Loan)		200 0 0
„ Cash Balance at Bankers ...	352 17 3	
„ Petty Cash in hand... ...	1 0 3	
		353 17 6
		£2,248 8 1

Notices.

THE TREASURER'S GOLD MEDAL FOR CLINICAL SURGERY has been awarded to Mr. G. S. Simpson.

THE RICHARD BREDIN PRIZE FOR CLINICAL STUDY has been awarded to Mr. Caleb T. Hilton.

Medical Department of the Navy,
Admiralty,
Northumberland Avenue, W.C.
11th June, 1900.

An Examination of Candidates for entry into the Medical Department of the Royal Navy will be held on 27th July next, and following days, at Examination Hall, Thames Embankment.

Not less than Fifteen Commissions, as Surgeon, will be offered for competition,

The forms to be filled up by Candidates will be supplied on application to this Department.

H. F. NORBURY,
Director-General.

SHORTHAND FOR MEDICAL STUDENTS.

The Society of Medical Phonographers offers for competition among registered medical students two prizes, each of the value of £5, one for those studying in England and one for those studying in Scotland or Ireland, for proficiency in the groundwork of phonetic shorthand (phonography). A second prize will be given in each case, consisting of one year's free membership of the society and a selection from its shorthand publications. The examination will have for its chief object, *legibility, accuracy, and neatness of writing rather than speed*, and will consist of two simple tests—

(*a*) The ability to read at sight a passage of a few hundred words printed in a freely vocalised style of shorthand.

(*b*) The ability to write shorthand at a low rate of speed (sixty words per minute) and to produce a correct longhand transcript of the passage so dictated. In this test the quality of the shorthand note as well as the correctness of the transcript will be taken into account.

The passage used in each test will consist of some straightforward medical matter.

The examination will be held the first week in November simultaneously in London, Edinburgh and Dublin, and at any provincial medical school in the United Kingdom at which not fewer than three candidates shall offer themselves.

Intending candidates are requested to send in their names at as early a date as possible to the examination secretary (Dr. Gray, Beaumont Street, Oxford) who will inform them in due course as to the precise date and place of examination at each centre.

Applications are invited for the post of Anæsthetist attending in the Out-patient Department on Tuesdays, at 1.30 p.m., and should be addressed to the Treasurer, The Counting-House, Guy's Hospital, S.E., on or before Saturday, July 14th.

Guy's Hospital, July 4th, 1900.

Nursing News.

MATRON'S OFFICE.

The nursing staff and others of Guy's Hospital have again been invited by the Treasurer and Mrs. Cosmo Bonsor to garden parties at their beautiful Surrey seat at Kingswood Warren. The first took place on Monday last. The guests numbering about 130 left London Bridge, South-Eastern Railway, in a special train, at ten minutes to two, for Kingswood Warren, where they were met by Mr. Bonsor, and at once proceeded to the house, either walking or driving, where Mrs. and Miss Bonsor were awaiting them.

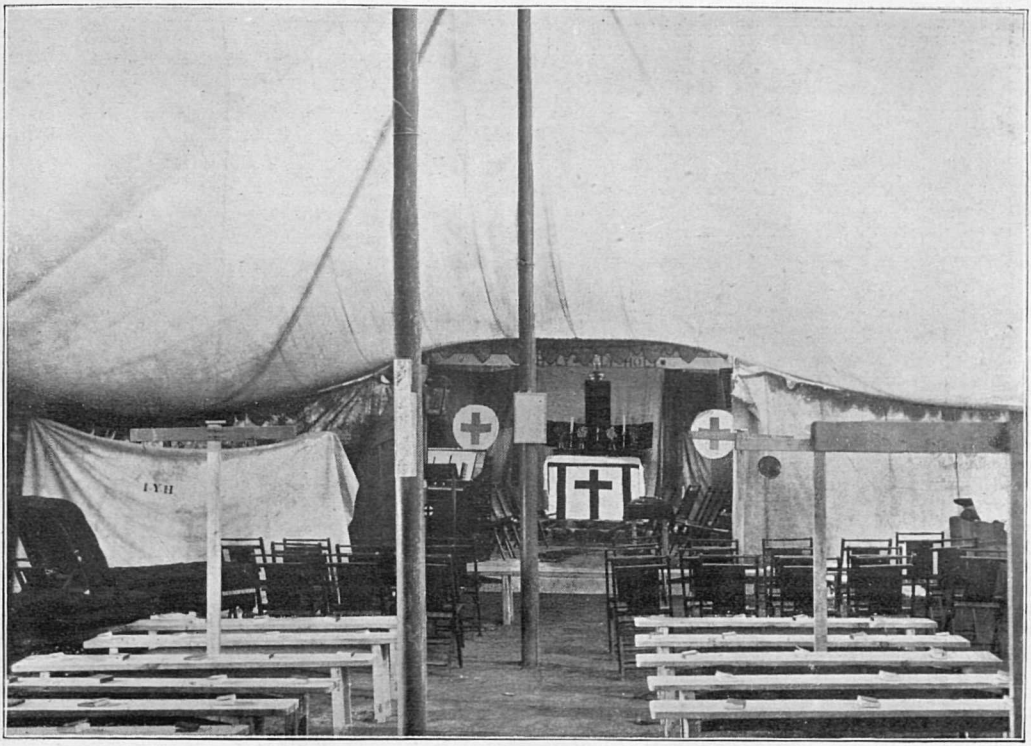
The weather was most unpropitious; notwithstanding the rain, however, the guests seemed to thoroughly enjoy themselves; and after light refreshments were partaken of, some wandered through the rooms, which were thrown open to them, or sat and listened to the Blue Hungarian Band which was discoursing sweet music in the hall, and others, braving the elements, visited the Church, farm, garden, greenhouses and stables.

At five o'clock a cold collation was served in the dining room, and at half-past six the party took leave of Mrs. and Miss Bonsor and started for the station. As the train left Kingswood Warren, hearty cheers were given to Mr. and Mrs. Bonsor, and Guy's was reached at a quarter to eight.

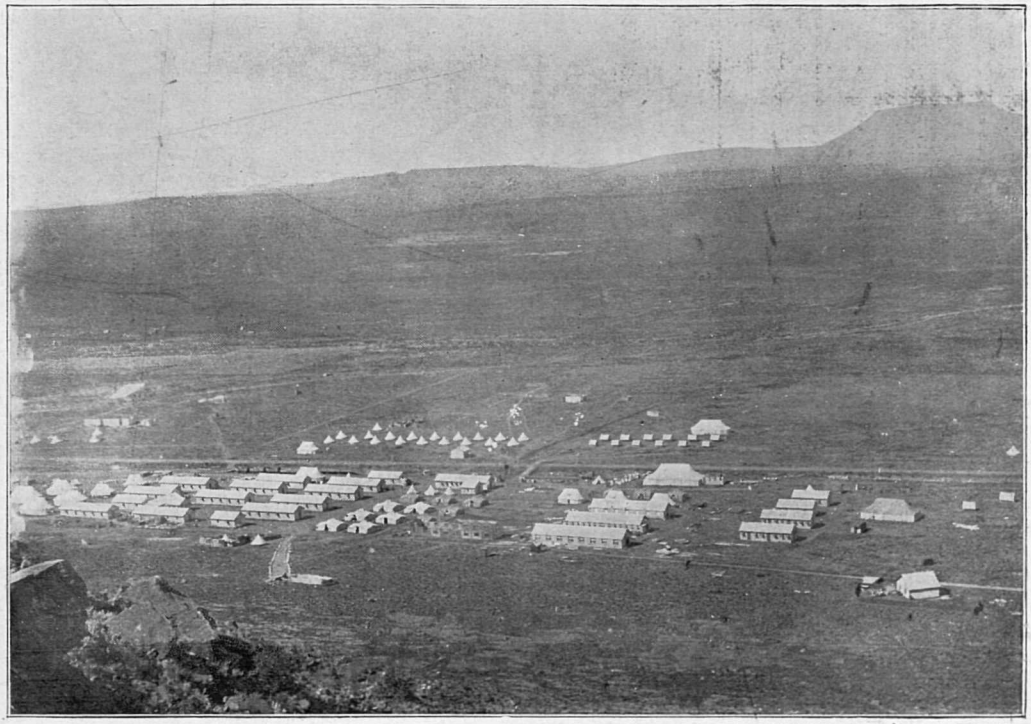
The second garden party will take place on Monday next, and it is to be hoped that the weather will be fine.

On June 30th Nurse Scholfield, Head Nurse in Bright ward, left for her holiday, previous to taking up holiday work, and Probationer Baker was appointed Head Nurse in Bright ward.

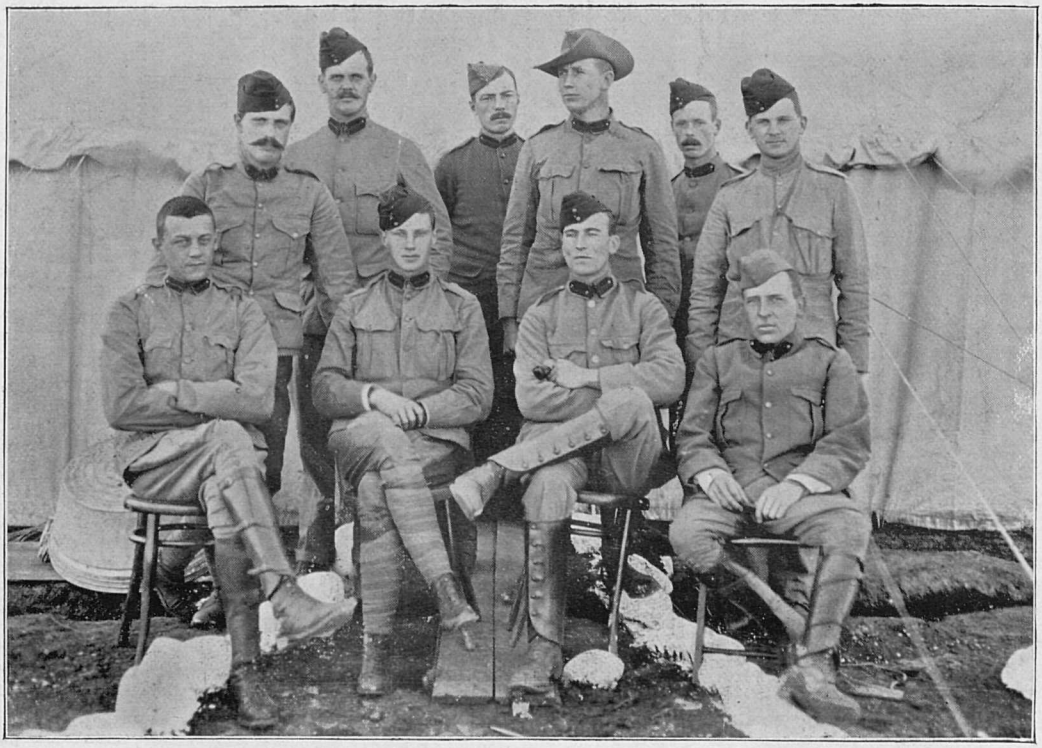
WE have received from Messrs. Burroughs, Wellcome & Co. two new additions to their list of therapeutic agents. Quinine Hydrobromide is now put up in three-grain tabloids and will be useful in some cases of intolerance of Quinine. Although the Hydrobromide is credited with the least tendency to cinchonism, and as such should always be tried where other salts are not tolerated, yet there are unfortunately many to whom even the Bromide is impossible. The other sample received was that of Opium Extract "Enule." This rectal suppository contains one grain of opium, and is packed in a tinfoil sheath, which protects it from atmospheric influences to a great extent. The well-known torpedo shape makes its retention in the rectum easy.



The Chapel.



Bird's Eye View of Hospital.



The Ten Surgeons' Dressers of the Imperial Yeomanry Hospital.—(Six are Guy's Men.)

Nurse Barnes' First Tea Party.

Passim.

Prize-day, nineteen hundred, will be chiefly remembered for the fact that it was one of the few functions of the hospital which were attended with fine weather. The morning was not promising, but the faint hope of fine weather extended by lunch time, was amply substantiated later in the day. Great efforts had been made to make the Park look tidy with generally successful results, and the presence of a band-stand, opportunely placed on the most obviously sparrow-ravaged site, did great service in this direction. When the visitors began to arrive, a whole army of stewards, assistant-stewards, deputy - assistant - stewards, police, commissionaires, not to mention permanent officials, pounced upon and harassed them with extreme vigor, that they might be duly and properly impressed with the majesty of the afternoon's proceedings. But the final *mise-en-scène*, the combined display of all degrees, "apparelled in magnificent attire," brought down the house, and reduced the unhappy few without wedding garments to weeping and gnashing of teeth.

The wards were all thrown open to visitors, and each Sister had worked her hardest to outvie her colleagues in floral decorations. Some wards were veritable flower gardens; indeed the garden party might with more appropriateness have been held in the wards, and the park abandoned to its native dwellers. It would be invidious to mention any ward in particular for especial praise, but we cannot refrain from assuring each Sister confidentially that her ward was really the prettiest in the hospital. Unfortunately Astley Cooper could not be finished in time. Apart from the beds and the usual furniture, however, the ward was as it will be in future, and created much favourable comment from old Guy's men, who were accustomed to the old order of things. The honours of the building were no longer bestowed entirely on the wax model museum; a small exhibition incubator in Victoria created so much enthusiasm that it became necessary to post a sentry to relieve the congestion.

In the Court Room, and therefore unfortunately passed over by many visitors and old Guy's men, was exhibited a life-size portrait of Dr. Pye-Smith, the gift of the Hospital Staff. The pose is excellent, but the likeness is hardly as happy as one could wish. Still, it must not be supposed that the portrait is not good; all we wish to imply is that Mr. Draper has hardly caught the best facial expression. As a work of art, the portrait is well worthy of the artist who executed the magnificent fresco in the nurses' dining hall. By the way, photographic reproductions of Dr. Pye-Smith's portrait are published, with the artist's consent, by W. E. Gray, of 92, Queen's Road, Bayswater, at half a guinea a copy.

An annual and always welcome festivity takes place to-night in the college library at 7 p.m., under distinguished auspices. The session of the Debating Society, of which it marks the end, is one of the most successful we can remember, and the dinner is thereby marked for success. Dr. Stevenson has kindly consented to preside, and it is expected that several members of the Staff will support the senior lecturer. It is unnecessary to remind our readers that they are all members of the Society and specially urged not to miss what is likely to prove a most pleasant evening. The Secretary would be obliged if those who will be present will let him know as early beforehand as possible, for the convenience of the caterer. The dinner is priced at two shillings.

While watching the sports from the shelter of the Pavilion, the conviction was forced upon us of the necessity of paving in some way the area directly around the club-house. The mud which was carried into the rooms from just outside was simply enormous, and much of this might have been saved by a belt of asphalte encircling the Pavilion. There is a splendid opening here for some benefactor who would like to "do something" for the Clubs' Union, and who has not as yet formed any definite ideas on the subject. And if his generosity would carry him still further, he might wainscot the large room on the ground floor with oak panelling, on which the names of the men in the various teams could be inscribed. These are two very excellent suggestions at present beyond the means of the Clubs' Union, but worthy of the serious consideration of any future benefactor.

The first of Mr. Cosmo Bonsor's garden parties, for which the nursing staff "and others" received invitations, was marred by the steady downpour of rain which lasted during the whole of the afternoon and evening. Despite the wet weather, however, the visit to

Kingswood Warren was most enjoyable, and was well appreciated by those present. It is to be hoped that the spell of fine weather which has set in at the moment of writing will be carried over to next Monday, in which case the second garden party will be held under ideal conditions.

OUR victorious sister hospital, St. Mary's, has added another laurel to her athletic record, and the athletic shield to her smoking-room. Guy's had the most execrable luck in the Inter-Hospital meeting, and in losing the shield unquestionably the better team lost. St. Mary's turned out but two representatives, each of whom won two of the "field" contests, while Guy's won the three "sprints," and had in addition no less than six second placings. The fact that ten medals fell to our share makes it extremely anomalous that we should have to be content with second place, and at the risk of being suspected of inability to suffer defeat, we think it only just to our representatives to point out that by any other method of scoring than by first placings alone, we should have easily secured first place. It seems evident on the face of it that four firsts in field events are not of equal value with three firsts in flat contests and six mixed seconds. Still, while the scoring stands on first placings alone, it will still be possible for a hospital to win the shield by two representatives only, and possibly by a single athlete.

IN another column we publish the first report of the Davies-Colley Memorial Fund Committee, with a preliminary list of subscribers. It will be unnecessary on our part to do more than call our readers' attention to this project. The memory of Mr. Davies-Colley is still fresh in our minds, and Guy's men, both past and present, will welcome this chance of giving tangible evidence of their affection for our late Surgeon and Teacher.

BY the time these notes are published the Biennial Dinner will be a thing of the past. Everything, from choice of chairman to choice of rendezvous, points to a most successful evening, and we hope in our next issue to give a full account of this interesting reunion. In this connection, the secretary's report of the fiftieth anniversary dinner of the United Guyite Club is of pathetic interest. This club was formed in 1850, and at that time numbered twenty-eight members. Of this number, sixteen have since died, and one (Cleaton) resigned, while the rest have continued in the club. The chairman at the first dinner (Mr. Bisshopp) took the chair again at the jubilee festival, and there were present besides, Messrs. Duke, Ringer, Stocker and Stevens. Mr. Thomas Bryant, the hon. secretary, was prevented by his bereavement from attending. Ill-health had rendered necessary the absence of the other members, and it is feared that the club will soon be numbered among the things that were, for of the members present, "all were over seventy and one nearer eighty."

THE annual general meeting of the Guy's Hospital Ladies' Association, was held on Wednesday, June 20th, in the Governors' Committee Room. Mrs. Cosmo Bonsor, the president of the association, took the chair in the unavoidable absence of Mrs. Benyon. An interesting report was read of the progress of the association during the past year, and samples of the clothing contributed by the members were on view in Mrs. Perry's drawing-room. The members afterwards took tea together, and some of their number were shown round the hospital by the Matron and sisters. The report showed that there are now 429 members, of whom 157 belong to the main body, the rest being divided amongst nine local branches in various parts of the country. The association, in addition to providing clothing for destitute patients on their discharge from the hospital, arranges for some of its members to visit the various wards on stated days. The finances appear to be in a satisfactory condition, as evidenced by the fact that last year, and again this, the committee have been able to hand Mr. Cosmo Bonsor a cheque for £100 to be devoted to the maintenance of two beds in the maternity ward. The sisters who were invited by the vice-president to take tea with the members of the association, bore testimony to the enormous boon the clothing contributed by the association to their patients when sent away to convalescent homes.

ON looking through the list of members of the association, we were struck with the small number of ladies bearing the names of present students of the hospital. Our "sisters, cousins and aunts," not to mention our mothers, naturally take a great interest in the institution where we as students are spending so much of our lives. We ventured to suggest to the secretary that many of the students would be

glad to interest their relatives in the good work of the association, and she on her part stated how glad she would be to welcome such as members. The difficulty was to make the association known amongst the students. The porter would rebel against a mass of circulars addressed to the students at the hospital, and the Dean would look coldly upon a suggestion that the students' private addresses should be communicated to any unauthorised person. We mutually agreed that the GAZETTE might be a valuable means of making known the fact that the secretary, Mrs. Lauriston Shaw, of 64, Harley Street, would be extremely pleased to forward a report to any lady whose name and address might be sent to her by one of the students, and would welcome any new members who might be introduced in this way. The minimum annual subscription is half-a-crown, and each member undertakes to contribute two garments a year. If the present students of Guy's would take the matter seriously in hand, the number of members of the association might be doubled in the next twelve months, and its useful work correspondingly increased.

WE are indebted to Nurse Barnes for the photographs of the Imperial Yeomanry which appear in this week's GAZETTE. Nurse Barnes has sent an interesting and chatty letter home, in which she deals with the hospital question from the point of view of the nurse, and as such, her letter is of value in the present crisis. On this question we hardly think, however, that it will be necessary to do more than refer our readers to the letters of Mr. Fremantle which have appeared from time to time in these columns. An intelligent reader will find much food for thought in the earlier letters, and will be able to form a fairly accurate estimation of the condition of the hospitals, more especially those in the immediate vicinity of Bloemfontein.

Appointments.

STAFF APPOINTMENTS.

THE following appointments and re-appointments have been made by the Treasurer upon the recommendation of a Staff Meeting:—

DR. FAWCETT.—Teacher of the Medical Pathology Classes.

MR. R. H. J. SWAN.—Demonstrator of Anatomy and Biology.

MR. PAKES.—Demonstrator of Bacteriology and Sanitary Science.

DR. STEVENS.—Demonstrator of Biology.

Mr. G. B. SMITH.—Obstetric Registrar and Demonstrator of Microscopical Pathology.

DR. BEDDARD.—Demonstrator of Physiology.

DR. SPRIGGS.—Demonstrator of Physiology.

MR. ORMOND.—Ophthalmic Registrar.

DR. HYSLOP.—Demonstrator of Psychology.

MR. PAYNE.—Curator of Dental Museum.

DR. COCK.—Dental Anæsthetist.

DR. LANCASTER.—Dental Anæsthetist.

MR. OGLE.—Dental Anæsthetist.

MR. R. P. ROWLANDS.—Dental Anæsthetist.

MR. ROUW.—Assistant Dental Surgeon and Lecturer on Dental Mechanics.

MR. PILLIN.—Assistant Dental Surgeon and Demonstrator of Dental Mechanics.

MR. BAKER.—Assistant Dental Surgeon.

MR. PARFITT.—Demonstrator of Practical Dentistry with Extraction Classes.

MR. PAYNE AND MR. DOWSETT.—Demonstrators of Practical Dentistry with Revision Classes.

MR. HINCHLIFF AND MR. CAMPKIN.—Demonstrators of Practical Dentistry with Probationary Classes.

DR. BEDDARD AND DR. SPRIGGS.—Joint Demonstrators of Dental Microscopy.

July 3, 1900.

CIVIL.

BELL, H. T. S., F.R.C.S. Eng., has been appointed Health Officer at Wallungarra, Queensland.

BERRY, T. P., M.B. Lond., L.R.C.P., M.R.C.S. Eng., has been appointed Second Assistant Medical Officer of the St. Saviour's Infirmary, East Dulwich Grove, *vice* J. W. Pridmore, resigned.

GOLDING-BIRD, C. H., M.B., F.R.C.S., has been appointed an Examiner in Surgery at the University of Cambridge.

HOPKINS, F. G., M.A., M.B., B.Sc., has been appointed an Examiner for the Gedge Prize in Physiology, University of Camb., to be awarded next Michaelmas Term.

WALES, T. G., M.R.C.S., has been re-appointed Medical Officer of Health by the Downham Market Urban District Council.

MILITARY.

The undermentioned gentlemen are appointed Surgeon-Lieutenants:—WILLIAM WATSON and ARTHUR TRESCO FRANKLYN BROWN, 4th Volunteer Battalion the Queen's Own (Royal West Kent Regiment); WILLIAM F. BYFORD, 1st Volunteer Battalion the Royal Welsh Fusiliers.

NAVAL.

Surgeon HERBERT DENNY, R.N., is appointed to the *Duke of Wellington*, additional for disposal.

Some Notes on the Imperial Yeomanry Hospital.

Imperial Yeomanry Hospital,
Deelfontein,
June 4th, 1900.

I have been away from this place and did not get back in time to write to you last mail. I went with Surgeon-General Wilson, who is the principal medical officer of the forces in South Africa, and who was going north to inspect the various hospitals at Bloemfontein and then on to Kroonstad. We were kept four more days than we expected in the former place before the railway was opened to the latter, and as General Wilson wished to take up with him to Kroonstad fifteen nurses and a dozen doctors, besides a quantity of medical stores, it would not have been economy of time to have attempted any of the hundred and twenty miles by the slow ox waggon convoys, which kept open the communications before the railhead had reached Kroonstad.

There is a terrible epidemic of enteric fever scourging the army. In Bloemfontein alone there are over five thousand sick, most of them with enteric. In Kroonstad we found the three hotels as well as the Town Hall and the Church, the latter two being the only solid buildings in the place, converted into hospitals, even the billiard tables being requisitioned to accommodate enteric cases.

Each was covered with officers, for they were the most comfortable places that offered. Now that the railway is opened the Surgeon-General is rapidly pushing up adequate hospital accommodation, and as Lord Roberts is already in Johannesburg, where I hear there are many public buildings and hotels that will lend themselves to this purpose, he will shortly be able to establish hospitals there also. We haven't heard yet whether the bridge over the Vaal has been blown up. The possibility of providing adequate hospital accommodation north of the Vaal depends entirely upon the question of how early railway communications can be established and the site selected for the advanced hospitals. At each river that a bridge has been blown up, and there are three between Bloemfontein and Kroonstad, a "deviation" track has to be made by the engineers down the near side of the bank of the river (a descent of say thirty to fifty feet) across a temporary low bridge whose pillars are made of boulders or of sleepers, and up the far side of the bank. Each such deviation delays a train considerably, for the engines are all in a more or less worn out condition and are seldom able to pull their load up the steep ascent without a sub-division of the train into two or three fragments, each of which is taken up separately until level ground is again reached; and each train delayed in this way affects the whole section of the line, for as the track is always in this country a single one, not only the trains coming behind, but also those approaching from the front are kept waiting until the one in difficulties arrives at the next crossing station. As an instance in point, the train we travelled by from Bloemfontein to Kroonstad, although it was the first to do the journey, and therefore had the line open, took twenty six hours to accomplish the hundred and twenty miles. Nor are these difficulties of inefficient engines and deviations of the line at the bridges the only ones with which we have to contend.

There is also a great scarcity of fuel and a still more pressing scarcity of water, which not infrequently renders it necessary for an engine-driver to abandon his train, and run his engine on to the next place where there is enough water (once it was thirteen miles) to fill his tanks, and then back again to pick up his train. On my way down from Kroonstad, when again I was travelling in a train which had precedence of all others, because we were carrying down two hundred and forty-one sick from the front, we passed three trains trying to go in an opposite direction but all hung up in a siding. They contained the siege artillery and heavy guns destined to take part in the destruction of any town which shows less wisdom than the ones our army have recently occupied. The occupants of these trains were all very annoyed because the fourth one which had been running behind them all day had had the sense to send its engine back thirteen miles to the Sand River to refill its tanks, and thus replenished had slipped by the other three engines which were waterless. It was an awful experience travelling down with these two hundred and forty men. All but sixty had to travel in open trucks, for the simple reason that there were no closed carriages except what our party had come up in the night before. The nights are very cold indeed here now, but the hardships of these men were nothing to those of their less fortunate comrades who, in the days previous to the re-opening of the railway, had had days and nights of slow jolting in ox-waggons before they reached the railhead. My two hundred and forty-one sick had the further good fortune to have two blankets apiece and a sufficiency of food and stimulants, which we were able to serve out by means of telegraphing ahead to warn the railway staff officers at the various stations to have boiling water ready for use. Most of these poor fellows had enteric; a few were wounded. There were a midshipman from the *Doris* and a major in the Royal Artillery who lent me invaluable aid in skipping along the trucks and ministering as best we could to the sick. We took leave of the poor fellows when the train ran into the special siding of one of the general hospitals at Bloemfontein, and brought its number of sick up to the huge total of eighteen hundred.

The victorious advance of Lord Robert's army through the Free States was carried out, as you know, for the most part along the line of the railway, and you can trace the route for some hundreds of miles by the sight, and the scent too, of dead horses.

Nearly everybody one has met lately seems to think that the actual fighting is practically over. I hope it is not a case of the wish being the father to the thought, for most people are getting very tired of the war and

long to get back to civilization. Nothing, I fear, but an early unconditional surrender of the Transvaal, and the sending home of most of the troops, will cut short a terrible epidemic of enteric, unless indeed the cold weather which we have lately experienced should, by staying its spread, as there is room to hope it may, prove a blessing in disguise. I have had some most interesting conversations with Boer officers, prisoners in Bloemfontein, who were awfully pleased at being taken some cigars and some provisions to supplement the Government supply. One of these in particular was in the Transvaal artillery, and a very intelligent and well-educated man. He spoke English fluently. Many things which he said interested me. They say that the hope of the ultimate success of the Republican forces depended from the first entirely upon their President's reiterated promises of foreign intervention, without which they never for a moment thought they could win in the long run. First it was Germany who was to help them, then Russia, and lastly America. They declared that they had eighty thousand men in the field from the first, which was more than I thought; that there were still some forty to fifty thousand. That at least two hundred and fifty were killed and wounded at Maggersfontein, which I take it is more than most of us thought. That they *do* dread lyddite more than anything else. It was great news to them that their shells often failed to explode, and they say that frequently ours also failed, especially when they struck soft ground. They have practically no waggons left now, nearly all of them being worn out, or broken, or captured, or blown to pieces, and their horses were rapidly dying from the scarcity of grass in this winter season. Their stock of remounts is exhausted.

They are hopeless now to do anything except increase the bill that their land will have to pay, and the consequence is that every intelligent burgher is hoping from day to day that their President will surrender and save further bloodshed and destruction of property. They say that if there is another battle, which they very much doubt, it would be not at the Vaal (and so far they have predicted truly) but between Johannesburg and Pretoria. They know all about our new heavy guns and realise that their artillery could not have any chance. They criticise the tactics of their generals every bit as scathingly as the most discontented do ours, with the exception of Joubert and Grobbelaar, and they say that if our infantry and mounted infantry had pursued from the first their present tactics of advancing in extended order, and creeping on the ground and taking advantage of all cover, we should have had a walk over even in the early days of the campaign.

But those disastrous frontal attacks at the early stages at least had the good result of revealing to them the extraordinary pluck of our men, which they declared was past their comprehension until they saw it. They look upon six miles an hour as the speed an army like theirs can travel, including the mule waggons and guns, for every man was mounted, or was until horses began to run short. Although they know nothing of Lord Roberts' despatches, they were emphatic that Spion Kop ought to have been held by us, saying that their artillery was firing its parting shots by way of a rear guard action, while everything was being prepared for a retirement of their forces, which must have let us into Ladysmith straight away. They are emphatic that there is no fear of the mines being blown up, because it would alienate Europe, and that Pretoria will not be subject to a siege—"At least not if you bombard it," he added in a most naive way. They said there were only two forts on the south approach to the town, and that all the others were isolated and not in communication. Leyds, they say, will never dare show his face in Africa again; he would be shot. His pay is seventy-five thousand pounds a year, but out of that he has to pay all the foreign agents of the Transvaal. Sir Evelyn is the Englishman they state they fear most. They have sometimes been terribly badly provided with doctors and ambulance. Kruger refused several offers of help because he had entered into a compact with Germany that they should do it all. Not infrequently their wounded and sick had nobody but chemists to look after them, and there was absolutely no equipment, appliances, or transport, except ox-waggons. They had been only fairly well supplied with food throughout the war, but the requirements of their army are not many. Coffee is their chief drink. They declared that they had but little sickness, which it is difficult to understand or even to believe, when one thinks of the fearful amount of enteric we have had, in spite of our infinitely better sanitation, and of the fact that they took both enteric and measles down to Simons Town among their prisoners. By the bye, the death-rate from the former disease in the prison camp there suddenly fell directly the medical authorities prohibited the visits of sympathising Dutch women, probably indicating that the latter had been surreptitiously and indiscreetly feeding the patients with articles that should be rigidly excluded from the diet of any enteric case. They say that the burghers bear no grudge against England, thinking that we were drawn into the war by capitalists. They speak very highly of our magnanimity in the treatment of wounded and prisoners, and in the respect we have shown to conquered property, *e.g.*, the farms, but they said that the commandeering of cattle by the conquerors, readily admitted to be a necessity for the feeding of the army, will ruin many burghers, for they possess no other means of livelihood. If Joubert were alive, the war would end now that the other side is obviously without hope. That it was owing to that "great General's" reluctance to lose lives in onslaughts that neither of the three besieged towns were more hotly assailed. They marvel at the rapid way in which our engineers repair the railway, especially the bridges, and in view of the slight retardation thus caused to our advance, think it a great mistake of their countrymen to go on destroying the line, remarking that they will only have the more to pay in the long run. They recognize that the independence of the Republics is bound to go,

but in spite of impressions to the contrary, they say the Boor appreciates kindness, and that it won't take long for the two nations to fuse and settle down amicably under British Free Trade, which, while it will lessen the pay of the labourer, will lessen still more the price he has to pay for the necessaries of life.

The only obstacle to such fusion that they can foresee is what they call the "Company System as practiced at Kimberley," explaining that there the workman is paid good wages, but is forced on pain of dismissal to buy his necessities from stores run by the De Beers Company or its agents at prices so high as to take away all chance of saving money. The scarcity of grass in the winter would preclude a guerilla warfare being kept up. The northern part of the Free State certainly looks terribly inhospitable. The grass which about at the Orange River replaces the Karroo bush of the northern part of Cape Colony gets progressively browner and dryer as you go north. The herds of cattle and sheep have mostly been eaten up, and what few trees and shrubs there were have been used for fuel along the line of our advance. Even the wooden posts which support the iron wire fences at the side of the line have been demolished for the same purpose.

Food stuffs are very expensive. The water in the small streams at the bottom of the river beds is often very muddy. Dead horses are generally to be seen in the streams, and these streams are never above the strong suspicion of being typhoid infected. It is impossible for all water that is required for drinking purposes to be boiled; there is not fuel enough. Though indeed familiarity breeds such contempt in Tommy's breast that it is quite impossible to get him to adopt this or any other precaution even when he has the chance.

At Kroonstad the market-place is a large open square surrounded by single and occasional double-storied houses with plastered walls and corrugated iron roofs. When I was there it was alive with mounted Boers who had come in to give up their arms, or to be more accurate to make a show of giving up some arm or the other, for of course it is quite understood that a man does not give up his Mauser rifle and cartridges if he can beg, borrow or steal an obsolete weapon, the surrender of which will do instead.

After the dust and the smells and the straightened circumstances of the Orange River Colony, as it is now called, the site of this hospital and the general sense one always has got here at Deelfontein that much good work is being done with the help of adequate and comfortable, though not wastefully luxurious surroundings, was as welcome as spring. Everything is going on most swimmingly, and there is little that is new to relate, Lady Chesham arrived with her daughter just after my last letter to you, and has taken up her residence in her house between the two other private ones occupied by Colonel Sloggett and ourselves, and very glad we are to have her with us.

The new dairy is a great success. It is a corrugated iron shed, the sides being formed by light shutters all the way round, which can be pushed up so as to admit or exclude air from any quarter. The solid wall only comes up to about three feet above the ground. The floor is concrete, and slopes to a drain just outside so that it can be kept beautifully clean as well as cool. Two large sterilisers are placed just outside, and through these all the milk is passed. Sister Brereton supervises the reception, sterilisation, storage and distribution of all the milk, and also the distribution of our limited supply of eggs, being assisted by a staff composed of convalescent patients. A few days ago a train-load of sixty, composed entirely of Yeomanry, arrived, which is the outcome of a promise the Surgeon-General gave to us that he would as far as possible have the Yeomanry collected from the various hospitals further up country and forwarded to us here. It is, of course, not possible for us to get hold of every sick or wounded Yeoman. Some are too ill to be moved from the other hospitals, and some are laid up at small establishments off the railway line, where there is no suitable transport; but we have left no stone unturned to get all that we possibly could sent to us, and for this purpose we could not possibly have pitched on a site more accessible than this, which serves not only the regiments employed on the lines of communication south of us, and those in the rebellious districts up Prieska way, but also those on the western border and those who are distributed along Lord Roberts' line of advance through the Orange River Colony. Had we waited and established ourselves in Bloemfontein, we should only have been available for the latter troops, and in addition we should have lost some weeks of actual work at a time when an increase of hospital accommodation was very badly wanted. We arrived just at the right moment in the campaign, and an extended experience of other hospitals shows that we have succeeded in making ourselves far and away the most comfortable hospital of them all.

I am glad to say that all the sisters are in good health, but I think I told you in my last letter that one of our medical staff, Mr. Greenfield, had enteric. He is now convalescent, I am thankful to say, but unfortunately Dr. Fitz-Hugh has just been laid low with the same disease. With these exceptions we are all well and all happy. Nobody would be surprised to hear at any moment that the war was over, and nobody would be more pleased than Surgeon-General Wilson, who will then be able to utilize upon the staffs of the general or base hospitals, at present overworked to a terrible degree by this scourge of enteric, most of those doctors and orderlies who, as long as there is a possibility of any more fighting, will have to remain on duty with the field hospitals and bearer companies at the actual front. There will probably be a great deal of marching of our troops to and fro through the conquered country, and as long as bodies of men are thus occupied sickness will be arising, but it will, of course, be much more easily provided for when there is no further prospect of fighting.

ALFRED D. FRIPP.

Obituary.

Hugh Arnold Bryant.

Died at Bloemfontein, O.R.C., June 7th.

Guy's men of the years 1886 to 1890 will hear with much regret of the death from enteric fever at Bloemfontein, of Civilian Surgeon H. A. Bryant, R.A.M.C. He entered Guy's in 1885, and took the double qualification of the Conjoint Board in 1892. As his fellow student during the whole hospital course I knew him well. He was one of those who looked on the bright side of life, and his always courteous and gentle manner soon earned the affection of all who knew him, either as a friend or a colleague. Most sensitive himself, he never forgot the feelings of others, and he always seemed to live in the sunshine of the hill tops, and never to sink into the gloom of the valley mists. One of his strongest characteristics was his hatred of vulgarity, and he never tolerated for a moment references to the failings of others. Keenly critical himself, he was never caustic in his remarks, and whatever he thought of those he was thrown with, he always passed off their peculiarities with a humorous jest. Always smart in appearance, he must have hailed the day of Asepsis with enthusiasm, and his outward appearance was but a manifestation of the clearness of his soul.

He was thoroughly incapable of any selfish act, and these strong points were soon discovered and valued by his colleagues in the wards. Tireless in his efforts for them, he was most valued by his patients, and it always struck me that no sick man could have had a more gentle friend or a more conscientious helper. Those who knew him best will most feel his loss, and I am sure all old Guy's men will sympathise with Mr. Thomas Bryant, as one of those who at this sad time is mourning the loss of one of Guy's best sons.

F. H. O.

Richard Truman Fitz-Hugh.

Died of enteric at Deelfontein, S.A., June 15th, 1900.

Although the last few months have robbed Guy's of many of her best, yet I doubt if the full realization of the cost of war was brought home to us of the present generation so fully as when we heard of poor Fitz-Hugh's death. None of us knew he was ill, and the suddenness of the blow made it seem even more heavy.

R. T. Fitz-Hugh was born in 1872, and after being educated at Nottingham and Shrewsbury, came to Guy's in 1891.

He passed the Prelim. Sci. London in the following year, the primary Fellowship and Intermediate M.B. in 1895, and qualified M.R.C.S. and L.R.C.P. in 1897, and M.B. in 1898. Besides doing all the usual appointments he did Charity, Assistant House-Surgeon, Assistant House-Physician, and House-Physician to Dr. Pye-Smith. Such a record shows the worth of the man from a professional stand-point, but many have done as much and have failed to be as popular or as esteemed as was Fitz-Hugh.

From his entry at Guy's he took a prominent place in athletics; he was one of the best Association Football players we have had here of late years, and helped to bring back the Cup in 1894, besides captaining the team

1894–95, and in 1895–96. He also was in the cricket team which won the cup in 1892. In the social life at Guy's he was indispensable; he was Assistant Hon. Sec. of the Students' Club, President of the Residents, and for many years foremost among the "niggers" at Christmas, while few will forget his singing of a topical song, written by himself, at a Guy's smoking concert. And yet, versatile as he was, there was that in the man which his own modesty often concealed, but which those who knew him well always felt to be behind his good humour and cheeriness, a solidity of character, and an honest straightforwardness that made us all trust and admire him. An old friend of both his and mine said of him in a letter to me the other day, "I don't think there was anyone among all the men I worked with at Guy's for whose character I had a greater respect, or whose society gave me, and I think all of us, greater pleasure."

I think that sums up the feelings of all of us who knew Fitz-Hugh well. Perhaps some who may read this short estimate of the man may think that my affection and grief have caused me to paint his qualities in colours that are too glowing, but I think that those who were privileged to be his friends will hardly differ from my opinion, and of all those that have left Guy's of late, there are few whom we could point to with more satisfaction as a type of a sterling gentleman. There is some small consolation for us, if indeed there can be any, in the thought that he died in the midst of friends, and that all was done that human power could do for him. That he had endeared himself to all in the Yeomanry Hospital at Deelfontein, few will doubt, and, as Colonel Sloggett telegraphed home, his loss there is irreparable. To his family in their grief, perhaps the thought of what Guy's men think of him may in some measure serve to lighten their sorrow.

A. J. C.

Lawson Jerbis Hughes.

Killed at Kroonstad, S.A., June 11th.

Although one of the youngest of Guy's sons, and only a recent addition to the number of "men in the wards," L. J. Hughes had attracted many friends, both by his quiet good nature and an inherent something which cannot be expressed but which is a powerful factor in making friendships. The appalling suddenness of his death caused a profound sensation amongst his many friends, and it was some time before the official news was credited. "Tommy" Hughes, as he was affectionately called, was a very keen sportsman, and an enthusiastically patriotic supporter of Guy's. When the war broke out he was attached with another Guy's man to the Imperial Yeomanry Field Hospital as Mounted Medical Orderly, and it was in this capacity that he met his death at Kroonstad on June 11th. To his many friends there was the consolation, poor it is true, that he met his death in the happiest way, and we were glad that he died by the swift bullet and not by wasting disease. His loss will be deeply felt and as deeply regretted, both at Guy's, and at his old School, Marlborough.

Thomas Jones, M.B., F.R.C.S.

Died at Springfontein, S.A., June 18th.

We regret to record the death of a well-known and distinguished Guy's man, Professor Thomas Jones, F.R.C.S. Lond., of Owens College. Mr. Jones was, at the time of his death, Superintendent of the Welsh Army Hospital in South Africa, and his loss will be felt not only among his many friends at home but on the staff of that hospital, which has already suffered heavily. We are indebted to the *Manchester Guardian* for the following biography:—

Mr. Jones, who had not completed his fiftieth year, was the son of Mr. David Jones, of Derlwyn, near Carmarthen, who was a justice of the peace for the county. The elder Mr. Jones was instrumental, through his love for education, in establishing Derlwyn College, where Mr. Thomas Jones and a great many other Welshmen who have distinguished themselves in after-life, were students. Mr. Jones pursued his education at the Normal College at Swansea, passed the London matriculation examination, and afterwards began what proved to be a most distinguished career. His professional studies were begun at the Northern Hospital, Liverpool, in 1865, and continued at Guy's Hospital, London, where he remained for six years. During this time he passed the respective examinations for the degree of Bachelor of Medicine, obtaining honours in anatomy and the gold medal in chemistry and materia medica at the first M.B. examination (1872), and receiving honours in medicine, besides qualifying for the gold medal in midwifery at the second examination. He came to Manchester to take up the appointment of house-surgeon to the Royal Infirmary in 1872, and was pathological registrar from 1873 to 1876. In 1875 he became a Fellow of the Royal College of Surgeons of England. From 1876 to 1879 he was surgical registrar at the Royal Infirmary, and in the latter year he took his Bachelor of Surgery degree, being placed first in honours. He was appointed assistant surgeon at the Royal Infirmary in 1879, and on the death of Mr. Bradley in 1880, he was appointed full honorary surgeon. This office he held at the time of his death. From 1874 to 1880 he was surgeon at the Children's Hospital, Pendlebury. In the work of this exceedingly useful institution he took the keenest interest. He was, indeed, largely instrumental in making it one of the first hospitals for children in the kingdom, and on this account, if for no other, Manchester people owe him a deep meed of thankfulness. On his resignation of the office of honorary surgeon to the hospital he was appointed its consulting surgeon. In 1880 he was appointed lecturer on practical and operative surgery at Owens College, and in 1892 he accepted the chair of surgery at the College. Amongst other honorary positions held by Mr. Jones, and filled with unfailing activity, was that of surgeon to the Cancer Pavilion and Home. From the commencement of his career Professor Jones secured the complete confidence of the medical profession, and he very rapidly acquired an extensive and honourable

practice. It would not, indeed, be too much to claim for him that at the time of his departure to South Africa he had one of the largest surgical practices in the provinces. He was acknowledged to be a sound diagnostician and a most intrepid and skilful operator. He had filled the position of president of the Manchester Medical Society, and his contributions to the medical journals were numerous and important. He was also the author of a standard work on diseases of the bones, published in 1887.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Davies-Colley Memorial Fund.

DEAR SIR, — The Committee of the Davies-Colley Memorial Fund would be glad if you would insert the enclosed circular in the next number of the GAZETTE. It is being addressed to all Guy's men, and needs no words from me to commend it to all who knew Mr. Davies-Colley.—Believe me, yours very truly,

THOS. G. STEVENS, Hon. Sec.

DAVIES-COLLEY MEMORIAL FUND.

DEAR SIR,

The irreparable loss which our Hospital and Medical School have sustained, through the death of MR. DAVIES-COLLEY, while still with us, in active work, has awakened a general desire to perpetuate his memory.

It is felt that there are many who will be eager to testify, in some lasting form, to MR. DAVIES-COLLEY'S great ability, unvarying uprightness and daily devotion to duty. To this end, at a meeting of the Medical School Staff, it was decided to invite subscriptions.

The form which the Memorial shall take, will be determined at a meeting of the Subscribers, to be held at a later date.

Subscriptions may be sent to Dr. T. G. STEVENS, at the address as below.

We are, yours very truly,

CHARTERS J. SYMONDS, Treasurer.
THOS. G. STEVENS, Hon. Secretary.
8, ST. THOMAS'S STREET,
June 30th, 1900. LONDON BRIDGE, S.E.

The following subscriptions have already been received or promised:—

	£	s.	d.
H. G. Howse, Esq.	10	10	0
Dr. Frederick Taylor	10	10	0
Thomas Bryant, Esq.	3	3	0
Dr. Horrocks	10	10	0
W. H. A. Jacobson, Esq.	31	10	0
R. Clement Lucas, Esq.	10	10	0
Charters J. Symonds, Esq.	10	0	0
Dr. Hale White	5	5	0
Dr. Newton Pitt	5	5	0
W. Arbuthnot Lane, Esq.	5	5	0
L. A. Dunn, Esq.	5	5	0
Dr. Lauriston Shaw	5	5	0
Dr. F. W. Cock	2	2	0
John Poland, Esq.	2	2	0
Dr. J. H. Bryant	2	2	0
Dr. F. P. Weaver	2	2	0
Chas. Spurrell, Esq.	1	1	0
Dr. S. R. Alexander	1	1	0
W. Cock, Esq.	1	1	0
L. H. McGavin, Esq.	1	1	0
Dr. J. W. F. Jewell	1	1	0
W. C. C. Pakes, Esq.	1	1	0
Dr. John Robertson	1	1	0
C. D. Edwards, Esq.	1	1	0
S. W. McIlwaine, Esq.	0	10	6
G. Simpson, Esq.	0	5	0
H. L. Eason, Esq.	0	5	0
P. Turner, Esq.	0	5	0
H. A. Gaitskell, Esq.	0	5	0
E. W. Goble, Esq.	0	5	0
F. W. Brook, Esq.	0	5	0
A. E. Clarke, Esq.	0	5	0
L. Wilkin, Esq.	0	5	0
R. H. J. Swan, Esq.	0	5	0
W. L. Baker, Esq.	0	5	0
E. R. Thomas, Esq.	0	5	0
J. E. Taylor, Esq.	0	5	0

Sport.

Annual Athletic Sports.

IN excellent weather for fish and submarines our Annual Sports were held in the club ground at Honor Oak Park on June 21st last. From early morn to sloughy eve the rain fell in one continuous sheet, not falling in refreshing showers between intervals of glorious sunshine, but steadily driving and "reeming," splashing from roofs, trees and pavements, and spoiling clothes and tempers. Yet a more than ordinary number of enthusiasts came down to the ground, all the judges, many competitors, and Mr. Higgens, who had at short notice consented to act as President, and had, in a manner deserving the heartiest thanks of the club, determined to fulfil his promise. To the ladies who braved the elements, and came down in that awful weather, must be given the first meed of praise, and in particular we must thank Mrs. Bryant for her kindness in distributing the prizes. It was impossible to note all the ladies who were present, but some scorned even the protection of the pavilion and watched the proceedings at close quarters. Among these fearless ones were Mrs. Stevens, the Assistant Matron, and Sisters Astley Cooper and Patience.

The best item in the programme was undoubtedly, from the spectacular point of view, the Donkey Race, and when Mr. Higgens steered his unwilling beast past the post, the enthusiasm was immense. An additional interest was added to the final heat by the fact that the donkey which had romped in first in each of the other heats was not allowed to compete, and Mr. Higgens won on a mount chosen by chance. During the proceedings some muffled sounds emerged from a large pool on the course, in which the City of London Artillery were lying in ambush. There were no casualties on our side. Details :—

100 YARDS HANDICAP.—Heat 1: H. K. Lacey, 6 yards start, 1; F. M. V. Smith, 5, 2. Four started. Won by a yard. Time, 11sec. Heat 2: E. Morgan, 8, 1; S. P. Wadson, 1, 2. Five started. Won easily. Time, 10⅗sec. Heat 3: R. W. Allen, 4, 1; J. Hodson, 5, 2. Five started. Won by a foot. Time, 10⅘sec. Final heat; R. K. Lacey, 1; E. Morgan, 2. Won, after a good race, by two yards. Time, 10⅗sec.

PUTTING THE SHOT.—D. H. Trail, scratch, 1; J. T. Hicks, scratch, 2. Eight competed. Won by two inches Distance, 31ft. 9½in.

HALF-MILE HANDICAP.—A. M. Roome, 30 yards start, 1; D. H. Trail, scratch, 2; L. G. Nash, 15, 3. Seven started. Roome maintained his lead throughout and won by six yards. Time 2min. 8⅗sec.

HONOR OAK PARK SCURRY STAKES (donkeys to be ridden by members of the Hospital Club). One furlong.—Heat 1: Mr. C. Higgens's Nomination (Owner) 1; Mr. R. S. Roper's, 2. Seven started Mr. Cutler beat the starting gate, and got away with a length to the good. Rounding the bend, however, Mr. Higgens, who had been experimenting with the various styles of riding, and finally settled upon the Sloan fashion, drew out, and managed to carry his moke home by a head. Heat 2: W. Robson's 1; E. G. Wale's, 2. Mr. Robson had the most friends in the crowd, and won by a head. Heat 3: A. E. Cawston's, 1; W. B. Secretan's, 2. Nine started. Won by a length. Final heat: Mr. Higgens again gave a good display of horsemanship, and walked home an easy winner.

120 YARDS HURDLES.—Heat 1: J. E. Hodson, owes 6 yards, 1; H. K. Lacey, owes 5, 2. Four started. Won by three yards. Time, 19⅘sec. Heat 2: E. Morgan, owes 5, 1; E. M. Harrison, owes 5, 2. Three started. Each of the competitors fell, but Morgan eventually got home with a yard to spare. Time 22⅘sec. Final heat: J. E. Hodson, 1; E. M. Harrison, 2. Won by three yards. Lacey fell. Time, 19⅗sec.

THROWING THE HAMMER.—F. W. Sime, 77ft. 9in. 1; D. H. Trail, 76ft. 8in. 2. Five competed.

ONE MILE.—O. B. Travers, 50 yards start, 1; H. Barber, 35, 2. Seven started. M. A. Collins, from the 100 yards mark, cut out the pace for half a mile, when he retired. Barber then led to the last lap, where Travers came away, and won by nine yards. Time, 5min. 2⅘sec.

220 YARDS.—Heat 1: M. A. Collins, 25 yards start, 1; H. K. Lacey, 12, 2. Six started. Won, after a good race, by a yard. Trail was third, a foot off. Time, 24⅕sec. Heat 2: S. P. Wadson, 3, 1; H. Bacon, 12, 2. Won by two feet. Time, 25⅕sec. Heat 3: E. Morgan, 8, 1; E. M. Harrison, 12, 2. Three started. Time, 25⅘sec. Final heat: S. P. Wadson, 1; H. Bacon, 2. Won easily by three yards. Time, 24⅘sec.

VETERANS' RACE (150 yards).—C. T. Hilton, scratch, 1; T. R. Beale-Browne, scratch, 2. Three started. Won easily by six yards. Time, 17⅘sec.

440 YARDS.—R. W. Allen, 12 yards start, 1; S. P. Wadson scratch, 2. Seven started. Won by a yard. Time, 49sec.

LONG JUMP.—A. M. Roome, 20ft. 1in. 1.

HIGH JUMP was abandoned owing to the state of the ground.

From the Gazette's Special Pathologist.

E. H. G., AMERSHAM.—Tubercle bacilli are present in the sputum in fair numbers.

H. B., BUILTH WELLS.—Tubercle bacilli are present in the sputum in considerable numbers.

J. E., MIDDLESBROUGH.—No tubercle bacilli were found in the sputum.

H., REIGATE.—Tubercle bacilli are present in the sputum in large numbers. PATHOLOGIST.

Pass List.

University of Cambridge.

EXAMINATION FOR THE DEGREE OF DOCTOR IN MEDICINE.

W. Evelyn Alston.

University of Brussels.

EXAMINATION FOR THE DEGREE OF DOCTOR IN MEDICINE.

B. Burnett Ham.

Papers by Guy's Men.

A Case of Hæmorrhagic Pancreatitis. By John C. Uhthoff, M.D., M.R.C.P., and Edward F. Maynard, M.D.—*British Medical Journal*, June 23rd.

Marriage.

CARTER—TOONE.—On June 21st, at Emmanuel Church, Loughborough, Arthur Burnell Carter, M.R.C.S., L.R.C.P., of Dartford, Kent, to Edith Annie, eldest daughter of the late William Henry Toone, solicitor, of Loughborough.

ED.—S. H.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well a subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

July, 1900.

Sat. 21.—Messrs. Jacobson and Fripp's take-in; Drs., J. E. Collins and G. S. Davidson; Cl., T. P. Thomas.
G.H.C.C., I., Kensington, away.
G.H.L.T.C., I., Dulwich Park, away.
G.H.B.C., Run to Leatherhead.
Hos.-Scho. C.C., Wandsworth Prison, away.

Mon. 23.—Exams. for Junior and Senior Prizes for General Proficiency and for the Beaney Prize in Pathology.

Tues. 24.—First Conjoint Exam. begins.

Wed. 25.—Lectures cease.
G.H.L.T.C., Sydenham, away.

Thur. 26.—Messrs. Howse and Symond's take-in; Drs., A. C. Nash and J. F. Douse; Cl., J. M. Brydone.
School Exams. in Elementary Anatomy and Histology.

Fri. 27.—Summer Session ends.
Exam in Dental Microscopy, 2 to 5 p.m.
G.H.B.C., Run to Ongar.
Hos-Scho. C.C., St. Bart.'s Hospital, home.

August.

Thur. 2.—Messrs. Lucas and Lane's take-in; Cl., T. E. Holmes.

Sat. 4.—Hos.-Scho. C. C., Hanover, away.

Guy's Hospital Gazette,

JULY 21, 1900.

Pericarditis.

CLINICAL LECTURE BY DR. HALE WHITE.

May 23rd, 1900.

GENTLEMEN,—The cases that we will discuss to-day I think most of you have seen. You have probably noticed, when going round Philip ward, two boys opposite to each other, both of them suffering from pericarditis. One died the other day, and the other is still alive. I will take as the main part of the lecture the case of the boy who died, because I can show you the changes in his viscera found at the post-mortem last week.

He was a boy eight years of age, and came into the hospital on the 16th of February this year. From February 13th to May 13th, 1899, he was in the hospital under Dr. Pye-Smith for acute rheumatism, mitral regurgitation and pericarditis. When admitted in February of this year he had a temperature of 100·6°, pulse 136, respiration 44, and some dyspnœa. To save time I will at once tell you the physical signs that he showed when he came in. Some I will put on the diagrams (see Figs. 1 and 2),

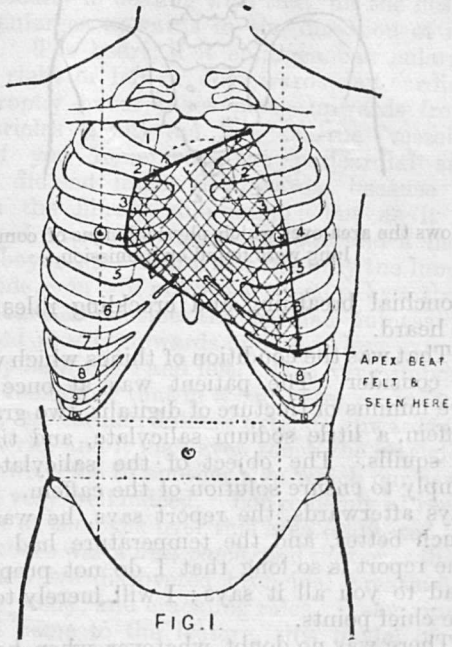

FIG. 1.

Shows the area of pericardial and cardiac dulness in front on admission.

and I will write them all on this board. Now this large area (indicated) of the front of the chest was completely dull. When you put your hand on the chest you could feel a thrill suggestive of pericarditis all over that extensive dull area. The apex beat of the heart could be felt here (see Fig. 1). All over the dull area a pericardial rub could be heard. Then turning to the back, the chief signs, the only ones I will give you, for I do not want to confuse you, the chief signs were, that over an area like this (Fig. 2) the note was dull, and bronchophony,

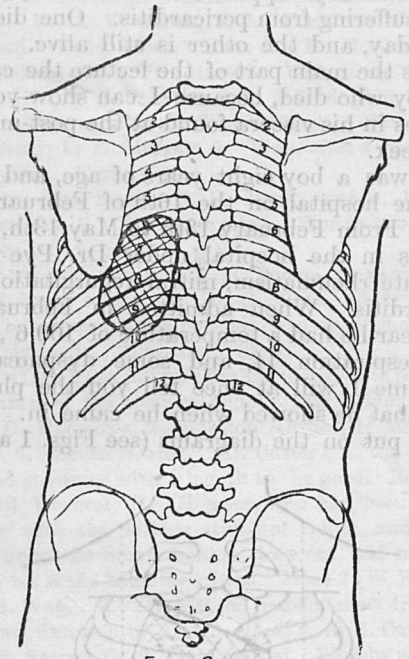

FIG. 2.

Shows the area over which physical signs of compressed lung were found on admission.

bronchial breathing and crackling râles could be heard.

That was the condition of things which we had to consider. The patient was at once given five minims of tincture of digitalis, two grains of caffein, a little sodium salicylate, and tincture of squills. The object of the salicylate was simply to ensure solution of the caffein. Three days afterwards, the report says, he was very much better, and the temperature had fallen. The report is so long that I do not propose to read to you all it says; I will merely tell you the chief points.

There was no doubt whatever when he came in that he had pericarditis; the rub could be both heard and felt. There being no difficulties therefore to discuss with regard to the diagnosis, we will enter at once on the subject of pericarditis. If I ask students anything about pericarditis one of the first signs they usually mention is *pain*. Well, in children pain is very often absent, and this boy illustrates that fact; he never complained much of pain over the pericardial region. Also, too, in children, not only pain, but *tenderness* is often absent. I do not remember that this boy at any time complained of tenderness. Then, again, children with pericarditis are unlike adults, in that they do not complain frequently of the subjective symptom of *oppression*, of something that is oppressing and stopping the heart, and which is very distressing in older patients. This boy, then, lacked these three signs.

You know that people with pericarditis have *pyrexia*. You remember this boy had pyrexia.

Then with regard to the *thrill*, what is there characteristic about that to call your attention to? In the first place, it may be very extensive, as it was in this case. In the next place, if it is local, it is generally felt best at the base of the heart, and a very characteristic and distinctive feature about it is that it is felt to be quite superficial under the hand. I do not think that when well marked it is likely to be mistaken for anything else. It is systolic.

Then as to the *rub*. There is often considerable difficulty in diagnosing the rub from endocardial murmurs. I will tell you the chief distinctive points. The most striking thing about a pericardial rub is that it is extremely superficial; you seem to hear it immediately under the end of the stethoscope. It is heard both during contraction and relaxation of the heart. It is commonly confined to one place. It is exceptional, except in very severe cases, to hear it loudly all over the pericardial region. And remember, very importantly for diagnosis, that it is not conducted in definite directions like most endocardial murmurs. You know that a systolic aortic murmur is conducted up to the right (indicated) and the diastolic murmur downwards (indicated). A pericardial rub has no definite direction like many an endocardial murmur, and that fact will help you to distinguish it. Then it is alterable. By pressing the stethoscope against the chest you may vary the intensity of the pericardial rub, but you cannot so alter the intensity of an endocardial murmur. Some authors say that a pericardial rub is never loud enough to be heard at the back. That is not true, because I have heard it there, but I quite admit that it is very rare to hear a pericardial rub at the back. Years ago

there was a woman of thirty-five, in Miriam, who had a pericardial rub that could be most distinctly heard at the angle of the left scapula. As a rule, with many exceptions, endocardial murmurs do not alter; most are constant in position day after day. Pericardial rubs, on the other hand, vary very much. One day you hear it best here, another day there, and so on. So that the pericardial rub, remember, is variable.

Now I come to another point, and if I question students upon it in examinations they usually tell me that as the effused fluid increases it separates the cardiac part of the pericardium from the fibrous part, and hence the rub disappears. That is rarely so. The natural tendency of the fluid, if the patient is lying on his back, is of course to drop to the back of the chest; and if he is upright, to drop to the bottom of the pericardial sac. So that whatever position you find the patient in, there will have to be a very large amount of fluid before it will come to the front and separate the heart from the chest wall and so prevent you from hearing the rub. It is a very common error to believe that the diffused fluid leads to the diminution or disappearance of the rub. These are the practical points which I thought it worth while to tell you about the rub.

And now we will pass on to the *effusion*. Remember that the chest wall or pericardial wall is most rigid in front; it is comparatively soft against the lung and down towards the diaphragm. So that it is rare for pericardial effusion to lead to bulging of the chest. I have seen bulging, but the amount of effusion has to be large to cause it. The best way to detect any bulging of the pericardial sac is to press your hand down in the epigastric angle, for the pericardial fluid may push down the diaphragm and gives a sense of resistance in the epigastric angle. Then, too, it may push down the liver, especially the left lobe, in the same way. But remember the amount of effusion must be large to produce these signs.

Another point about which there is often a little difficulty, is the position of the cardiac apex. The older observers of fifty years ago thought that in pericardial effusion, the effusion in some obscure way tilted up the heart so that the apex was higher than in health. The fact is undoubted that very frequently the beat of the heart is seen in an intercostal space higher than in health if the patient be suffering from pericarditis. The reason is that in such a patient you are not seeing the beat of the apex, but the position of the heart is so altered by the pericardial effusion, that some other portion of the left ventricular wall comes to the front and beats prominently against the chest wall, so that there is an apparent elevation of the apex, but it is only apparent. The visible point of contraction is often not the apex when there is a large pericardial effusion; it is some portion of the left ventricular wall that is seen to beat one space higher up than the usual seat of the apex beat.

Now that was in our case an important fact to remember, for the most obvious cardiac beat was seen and felt below the seventh rib (see Fig. 1), so that the real position of the apex was certainly not higher than this, because in pericarditis the apparent apex beat, that is, the visible beat of the left ventricle, is often higher than in health. Therefore we learn that in our case the apex must have been far out and below from its proper place, which shows conclusively the heart was very much enlarged.

Then with regard to the effect of the cardiac effusion on the cardiac movements. I need hardly tell you that it weakens them. It is not a natural condition for the heart to beat surrounded by a quantity of fluid.

To pass on to the next point—*the shape of the dull area*—I do not think you ought to have any difficulty in dealing with that, for the heart never enlarges upwards in the direction of its vessels. The heart, if it enlarges, can enlarge to the right or left or downwards, but cardiac hypertrophy never takes place upwards from the auricles along the line of the vessels. And, if you remember, the pericardial sac cannot distend much downwards, because it lies on the fibrous diaphragm; but as it is continued up on the vessels for one and a half inches beyond the heart, and has only the lungs at its side, you will not be surprised to hear that in pericardial effusion the cardiac dulness is increased mostly upwards and to a less extent laterally both right and left. It is very important to remember that in a bad case, as in our patient, the cardiac dulness extends upwards to the first rib, and it may even touch the clavicle.

Now we come to another sign which our case showed very well indeed. You remember I read out that at the back over this area (indicated in Fig. 2) there was a *dull patch*, and that over that dull patch we discovered bronchial breathing, bronchophony, and crackling râles. I saw, just before I came to the lecture, this model of a transverse section through the thorax, and I brought it in, because it shows you at once how that happens. Here in this transverse section

of the thorax you see the heart and the pericardium. If, especially as a patient is lying in bed, the pericardial sac contains, say, half a pint of fluid, the weight of the fluid compresses this part of the left lung between itself and the ribs at the back of the left side of the chest, and you get solid compressed lung between the pericardial sac and these ribs. The physical signs just enumerated as being heard over the back in this case are extremely important as showing considerable pericardial effusion, for they are just the signs given by compressed lung. You will notice that the position of the dulness, the bronchial breathing and the bronchophony, that is to say, the signs of compressed lung is just internal to the angle of the scapula. But reference to the model shows that to be exactly the position of the lung compressed by pericardial effusion, so we may infer that in our case the effusion was sufficient to compress the lung. Again, the larger the effusion the more the lower part of the lung tends to get compressed. So that in our case, as there was a great deal of effusion, a considerable amount of lung was compressed, and so we got the above signs over a large area. Many of you who have been round the ward have from time to time listened to those signs and been able to hear them for yourselves.

Then the *pulse* was *rapid*. That was another symptom the presence of which will not surprise you. And there was a great deal of *dyspnœa*. That, of course, is what you would expect, and if the amount of pericardial effusion is large, the patient almost always wants to sit up, because just as much as he lies on his back, so the pericardial effusion jams the lung against the ribs and increases his dyspnœa. Therefore he generally sits *propped up* because the pericardial effusion drops on to the diaphragm, and as a result it comes off the lung and the dyspnœa is relieved. So that most patients with considerable pericardial effusion sit up, as our patient did.

Next for the progress of the case. Very slowly the dulness indicative of pericardial effusion diminished somewhat, diminished, of course, chiefly up at the top and the side, because that is the part of the dulness which represents the effusion; and gradually the dulness became more and more the cardiac dulness of an enlarged and hypertrophied heart. But the signs of an enlarged and hypertrophied heart always remained, and indeed the heart may after pericarditis remain so much enlarged that it maintains to some extent and for some time the compression of the lung of which I have just spoken. If I remember right, the last time I listened to the other little boy he still showed these signs at the back of his chest, although the pericardial effusion had been absorbed some time, as far as I could make out.

The next point in the progress of the case. As the pericardial effusion became absorbed, gradually we were able to hear a mitral systolic murmur at the apex, and a murmur in the diastole, heard best at the apex, sometimes presystolic and sometimes mid-diastolic in rythm. The boy had several slight attacks of pleurisy, and suffered very much from vomiting, cough, and anæmia. I might remind you that these patients very often suffer from vomiting, and it is extremely difficult, almost impossible, to satisfactorily treat it. There are few symptoms I dislike more, because often I can do absolutely nothing for it, and every act of vomiting is, of course, an extremely severe strain on the heart. These patients often suffer profoundly from anæmia; why they should is a very difficult question which we cannot discuss to-day, but you must have often noticed that many persons with defective circulation suffer from anæmia.

On the whole the boy did well, but he never got quite well; he never got beyond occasionally being allowed up for an hour or two at a time, but he improved considerably. Then, as I shall point out to you directly, that which we had expected all along happened. He gradually became œdematous and waterlogged, and he died.

Now let us consider the post-mortem. Here are the viscera. Even at that distance away you can see that there has been severe pericarditis, for the visceral and parietal layers of the pericardium are adherent all over, and Dr. Bryant had to use some force to tear the pericardium off the heart. It is very interesting to note that the pericardium is firmly adherent, for on February 16th there was a loud pericardial rub, and the boy died in the middle of May. Therefore, three months after a rub is present (when the pericardium cannot have been firmly adherent) the pericardium is adherent. Inasmuch as it probably took a little time for the fluid to get absorbed from the back of the pericardial sac after the rub had disappeared from the front, we learn that in some two months the pericardium can become so adherent that it requires some force to pull it off. So that this case gives you some notion of the time it takes for the pericardium to become firmly and uniformly adherent all over the heart.

The next point. If you will come down afterwards and look at the mitral valve, you will see

that there is really very little, if anything, the matter with the mitral valve itself. But if you look inside the left auricle (indicated) you can certainly see, from all over the theatre, how white and opaque its lining membrane is. In other words, it shows what we call watermarking, and this is evidence that blood regurgitating from the ventricle impinged on the lining of the auricle, and that, therefore, the patient had mitral regurgitation—a fact which we gathered during his life from the systolic murmur that we heard. But you will say, "you also told us he had a murmur in the diastole, sometimes pre-systolic and sometimes mid-diastolic in rythm audible at the apex." That is easily explained. At the post-mortem room Dr. Bryant measured this mitral orifice and found that it was four and three-quarter inches in circumference, whilst the ventricular cavity, immediately under the mitral orifice was six inches in circumference, so that the ratio of the mitral orifice to the size of the ventricular cavity is as 19 to 24. The orifice is narrower than the cavity, that is to say, there is virtually a mitral constriction, and hence this diastolic murmur. Let me make this quite clear. If the orifice were the same size as the ventricle, the blood would not produce any diastolic murmur. The mitral orifice is considerably dilated; it has no business in a child to measure four and three-quarter inches, and the ventricular cavity is still more dilated; so that the mitral orifice is smaller than the cavity, and during the diastole the blood is going through a comparatively constricted orifice into a larger ventricle, and therefore a diastolic murmur is produced. During systole, the mitral orifice being so enlarged that the valves cannot meet, the blood passes back through the narrow aperture between them and produces a systolic murmur.

This discussion raises a very interesting point, because many have taught that the only cause for a diastolic murmur, heard best at the apex, is an actual mitral constriction due to endocarditis sealing together the mitral valve and making either a buttonhole or funnel-shaped mitral orifice such as you commonly see. For instance, Osler tells you that the presence of a pre-systolic murmur is positively indicative of a narrowing of the mitral orifice, except in the cases in which a Flint murmur indicates aortic incompetence. I am sure you will bear me out that there is no narrowing of the mitral orifice here (indicated). There has been no endocarditis to narrow the orifice at all, and certainly there is no disease of the aortic valves.

This case, therefore, teaches that a pre-systolic murmur may occur when the pericardium is adherent, even if neither mitral nor aortic valves are affected by endocarditis. Let me give you the explanation. Dr. Theodore Fisher who was at Guy's some years ago, collected a number of cases, and I have here a paper by him which will clear up the point that I am discussing. (See *British Medical Journal*, vol. 1, 1894, p. 906). He pointed out that very often you hear in children a murmur pre-systolic in rythm, audible best at the apex, in patients suffering from the effects of pericarditis. He collected a number of cases and showed that very frequently the mistake was made of diagnosing that a patient had mitral constriction, when at the post-mortem the patient was found to have nothing of the sort, but simply an adherent pericardium. Here are the figures. Dr. Fisher finds that among the thirteen children suffering from adherent pericardium due to rheumatism who died in Guy's Hospital during the space of seven years, in five instances a diastolic or pre-systolic bruit had been present at the apex, and yet the necropsy showed that the mitral orifice and the left ventricle were dilated, and the aortic valves were not thickened. In no case was there mitral constriction. The explanation of this fact is in most cases, I think, that the pericardium becomes adherent to the heart when it is dilated, and the heart is held out by the adherent pericardium. The pericardium can naturally hold the muscular tissue of the ventricle further out than the tough auriculo-ventricular fibrous ring. Consequently the cavity of the ventricle is more dilated than the ring, and therefore you get a relative narrowing of the mitral orifice, and hence the pre-systolic bruit. So that one point you have learned this afternoon is that it is by no means uncommon to hear, when the pericardium is adherent, a murmur that might be mistaken for a murmur of mitral constriction, namely, a diastolic or pre-systolic murmur, audible best at the apex, although at the post-mortem no constriction of the mitral valve is found, but we discover that the patient has merely got an adherent pericardium. That is a fact which it is important to remember, and I hope I have made the probable reason of it clear to you.

Because in this case, the heart failed to do its work properly, signs of increased backward venous pressure such as œdema appeared, and consequently at the post-mortem we found blood in the stomach, and, as I can show you, the kidneys are hard and tough, the spleen is hard

and tough, and the backward pressure was so great that you will see a number of blood extravasations into the liver, which, in addition, is fatty.

Next as to the lung. It is difficult to preserve specimens of lung nicely, but you will afterwards be able to make out that the base of this left lung (produced) is still compressed. You can perhaps see that at the bottom of it I can press out little or no air. But above (indicated) I can press out plenty; the lung here is open and full of air, which can be easily pressed out, but below (indicated) it is compressed and solid, and air cannot be pressed out. The reason it is compressed and solid is because of the pressure of the pericardial fluid and the enlarged heart. So that you have got ocular demonstration of the effect on the lung of pericardial effusion.

The most interesting thing perhaps to discuss about this case is the treatment and prognosis. All along we regarded the prognosis as very bad, and unfortunately events justified us. We did so for these reasons. In the first place the boy had had severe heart disease before. He was known to have a mitral murmur a year ago. In the next place, severe pericarditis must cause some myocarditis which will lead to cardiac dilatation. Just remember the position of this boy's cardiac apex. And at the same time severe pericarditis makes the sac of the pericardium soft and yielding, so that it no longer forms a resisting barrier to cardiac dilatation, and it dilates out like a great flabby sac that it is. Now the reason why we thought this case was irrecoverable, even when the patient first came in, was this: such very severe pericarditis as this boy had is almost certain to lead to universal adhesions of the pericardium, and we knew from the physical signs that the heart was dilated. So we were afraid that the pericardium would become adherent to the heart before it could recover from its dilatation. There is no conceivable drug which can ever make the heart to contract up again if it is held out in a dilated condition by a fibrous sac like the pericardium. And as the case progressed our view was shown to be correct, because after the effusion was absorbed it was quite clear that the heart still remained dilated; for the increased dulness largely remained, the abnormal position of the apex also remained, and the signs of compression of the lung did not entirely clear up. Then, too, the important point about the murmur that I have tried to bring out was very instructive, because the fact that the boy had cardiac dilatation was shown by our hearing the pre-systolic or diastolic murmur, which suggested that the ventricle was being held out more than the fibrous auriculo-ventricular ring. And so, as we expected, the child died with all the backward venous signs of an adherent pericardium. It is quite true that as the boy had had rheumatism his pre-systolic murmur might have been due to mitral endocarditis leading to mitral constriction, but he suffered so from signs of backward pressure that I think the pre-systolic murmur rather suggested that the ventricle was dilated in the way which I have already explained. Even supposing the heart had contracted up before the pericardium had become adherent, then the prognosis would still have been very grave, because under such circumstances the heart cannot grow. Therefore it comes to this, that the prognosis in cases of acute pericarditis, with subsequent adhesion of the pericardium, is bad in children, because the pericardium will either become adherent to the heart, holding it out and preventing its contracting up, or when it has become contracted up the adherent pericardium will prevent the heart from growing, and in either case the child will get backward signs such as this child had.

Now for the treatment. Just think what you want to do, and then you will see how to treat such a case. The treatment is much easier in the case of adults, because in them there is no question of the heart growing. But in children or adults you want to get the dilated heart back again to its normal size. Obviously, therefore, you must rest it, and the whole pith of the treatment really is *rest*. Some of you may remember recently the case of a man suffering from pericarditis to whom we rigidly gave directions that when he went out he was to keep very quiet; that he was not for a year to follow any laborious work, never to run or throw any strain whatever upon the heart until sufficient time had been given for the pericarditis and associated myocarditis to completely subside. And in the same way for weeks a child ought to be kept absolutely at rest so as to prevent any dilatation due to exertion. Throw no strain on the heart. Try to get the child to sleep at least nine or ten hours out of every twenty-four, because in sleep the cardiac contractions are not so powerful or so frequent. Try to avoid sickness, the act of vomiting throws a great strain on the heart; keep the bowels open gently once a day; straining at defæcation is harmful. See that the diet is light. And then from time to time give digitalis. The reason for this is that it powerfully contracts up the heart, and what you want to do is at all costs to get the heart contracted

up again to its normal size. External applications are quite unimportant; there is no evidence whatever that they help pericarditis. The application of a plaster or poultice often distresses the patient and makes it impossible for you to listen to the heart.

In our patient the pericardial effusion became so large that from time to time we wondered whether we should have to perform paracentesis. Only once during the years I have been here have I seen it done, and the patient died while the fluid was flowing, and once in the post-mortem room I saw a case in which it might have been done. So that you see, if you may judge by my experience, paracentesis is not often required. I have twice asked a surgeon to do it in cases in which the fluid has been large, and in each case the surgeon failed to reach the fluid. The reason why it is so difficult to reach is because the fluid accumulates chiefly at the back. I think most of you will go through the whole of your life without ever coming across a case in which it would be advisable for you to attempt paracentesis of the pericardium. True it is that in many cases it has been recorded that paracentesis has apparently saved the patient's life, but what I want to impress upon you is not to rush at it. It is very rarely required; and remember that it is very difficult to do. Further, I think you will find that cases in which it is desirable will become less and less common, because considerable pericardial effusions are probably less frequent than they were. Many good observers are distinctly of opinion that they do not see such a large number of cases of pericardial effusion now as formerly. Most likely the reason is that we treat rheumatism very much better than we did, and therefore we do not see so much severe pericarditis.

Five minutes will enable me to tell you all that is necessary about the other case; that of the little boy in the opposite bed. He came in on March 18th with a pericardial rub. We knew there was not much effusion because the cardiac dulness was not much increased upwards. He showed an interesting sign, known as Roche's sign, for on one or two occasions when we came round we noticed dulness in the fifth right intercartilagenous space. This is said to be symptomatic of moderate pericarditis, and to be due to the fact that a little fluid has gravitated down into the right-hand bottom corner of the pericardial sac. Its value probably is not great for it is often absent.

This boy, as the other boy, has those signs at the back which indicate compression of the lung. I need not go over them again. He has a systolic murmur and a pre-systolic murmur. As his pericarditis has not been so severe, it makes it more likely than it was in the last case that the murmurs are due to actual endocarditis of the mitral valve, and not to the conditions that have been described in the first case. (This patient died three weeks after this lecture was delivered. The pericardium was firmly adherent. There was endocarditis of the mitral valve.)

But before I conclude let me mention another case of pericarditis I have seen that will interest you with regard to the treatment. Many refuse to give digitalis for pericarditis, but I cannot help thinking that they are often in error. I saw two months ago a girl, nineteen years old, and her doctor had wanted to give her digitalis, but had been restrained by first one doctor and then another. When I saw the girl she had a loud pericardial rub; the heart was enormously dilated; you could feel the cardiac impulse in the anterior axillary line, she was apparently dying, and the doctor who was looking after her was rather distressed because he had not been able to persuade the other doctors that she should have some digitalis. I gave my opinion that she ought to have digitalis. It seemed to me the right thing to do, because, in the first place, it helps to contract up the heart, and, in the next place, it prolongs the diastole, so that it certainly rests the heart as regards time. Of course, the objection to it is that it makes the heart do more work. But it seems to me that this is overbalanced by the fact that you contract it up and protract the period of rest. Well in this particular case the result was most striking. Most patients when they are in such a desperate plight as that girl, would hardly live through the night. But after the digitalis, her heart contracted up again and approached two or three inches toward its normal position. It is true that ultimately she died some time after, but before coming to this lecture I asked the doctor his unbiased opinion, and he said he had not the slightest doubt that the digitalis was most distinctly beneficial to her.

Papers by Guy's Men.

Note on a New Medium for the Growth and Differentiation of the Bacillus Coli Communis and the Bacillus Typhi Abdominalis. By Alfred Theodore MacConkey, M.B., B.C.—*Lancet*, July 7th.

Two Cases of Concealed Accidental Hæmorrhage. By A. E. Larking, M.D.—*British Medical Journal*, July 14th.

Prize Day at the Hospital.

[BY THE GAZETTE'S SPECIAL CORRESPONDENT.]

THE Distribution of Prizes, always an interesting function at Guy's, took place on Wednesday afternoon, July 4th. The Right Hon. the Earl of Pembroke and Montgomery and Lady Pembroke were present to perform this pleasing duty, and Mr. H. Cosmo O. Bonsor, M.P. (Treasurer), presided over a large and distinguished company, comprising many well-known supporters and friends of the hospital, together with the prize-winners and others of the students. Accompanying the chairman on the temporarily erected platform in the Physiological Theatre were the following, besides Lord and Lady Pembroke:—Mrs. Cosmo O. Bonsor, Lord Cottesloe, the Hon. Sir Charles Fremantle, Sir Albert Rollit and the Dowager Duchess of Sutherland, Sir George and Lady Pilkington, Sir Joseph Fayrer, Mr. Arthur Morton, M.P., Mr. R. K. Causton, M.P., Mr. Cumming Macdona, M.P., the Dean of St. Mary's Medical School, the Prime Warden of the Fishmongers' Company, Mr. J. E. Gladstone, Mr. A. L. Cohen (the Master of the Grocers' Company), Mr. H. H. Raphael (the Master of the Salters' Company), Mr. J. S. Gilliat (the Master of the Coopers' Company), and others.

Amid loud applause the Treasurer rose to introduce the Earl of Pembroke.

The TREASURER: Ladies and gentlemen, I do not quite know who it is that writes the prescriptions for these interesting occasions, but somehow or other the first ingredient is always the infliction of a speech by your treasurer. I do not complain, because it gives me the opportunity of seeing a great number of friends and of telling them in short what has occurred in connection with Guy's Hospital during the past year. Of course, there is the melancholy side of each year's history, and on this occasion I regret to say that death has been very busy among the ranks of our Governors. Two who were present here on the last occasion, Mr. Richard Harvey and Mr. Shaw Stewart have been taken away from us. They were both keenly interested in the welfare of this hospital, and always ready to give advice in its administrative department. They were frequently at our Governors' meetings, and invariably attended when anything of interest associated with the good or well-being of the institution was in progress. And then when we come to the other side of our staff, I must allude with the greatest regret to the death of our friend Mr. Davies-Colley. It was extremely sad. He last year was amongst us doing most excellent work, but was suddenly stricken with illness during the winter, and was taken away a few weeks ago. I am glad to think that the staff at Guy's Hospital has decided to raise some lasting memorial to his memory in recognition of the good work he has done in the hospital. Passing away from the melancholy side of the past year's events, I am pleased to think that two of our seniors have joined the Consulting Staff, and both of them, Dr. Pye-Smith and Dr. Goodhart, are here to-day to show their keen interest in the hospital, and that the position they now hold in connection with it is not a merely honorary one. I think I may also allude to the losses that we have sustained in South Africa. One of our friends, Mr. Fitz-Hugh, whose death we saw the other day in the paper, was amongst the most promising of Guy's men, and one of those who a very few years ago received a prize. Well, ladies and gentlemen, after the prizes have been given away you will, no doubt, walk through the grounds of the hospital and see that a great deal has been going on during the past twelve months. You will notice, in the first place, that the Henrietta Raphael Nurses' Home, founded by our late Governor, Mr. Raphael, in memory of his wife, is gradually rising above the ground. And let me pause for a moment to tell you that when the plans were prepared there was a plan for a swimming-bath for the nurses, but, unfortunately, when the estimates came in, and the builder's contracts were brought to us, it was found that the expense of erecting the Home was so much larger than the sum originally provided, that it was necessary to cut out the bath. But let me give you the interesting information that since that became known, two sons of the late Mr. Raphael have most generously given the swimming-bath. (Applause.) Two other sons have also magnanimously come forward to perpetuate the memory of their late father by founding a fund to secure that those nurses who may break down in the service of the hospital should have the advantage of rest, with a view to their complete restoration to health and strength again. Behind the Nurses' Home you will see the laundry, which is gradually approaching completion. Naturally a laundry is an essential part of a large hospital, and the existing one became quite inadequate to our requirements, particularly when the enlargements to the hospital, effected through the Prince of Wales's Fund, were completed. When you get farther on into the surgical buildings you will see another ward, only finished last week, which is not yet occupied, and which has been undergoing repair, I mean Astley Cooper ward. This ward has not had any substantial repairs done to it since the foundation of the hospital, but it has now been renovated according to what are now believed to be the most modern scientific principles. Indeed, the same process is going on throughout the hospital, and I mention the fact because this is, of course, where the anxieties of a treasurer chiefly come

in, the providing of finance to carry on an enormous institution of this description. May I say that these occasions on which we meet annually are occasions which, I think, do a great amount of good by interesting our own friends in the work of the hospital, and, I hope, spreading the news of what we are doing within its walls to other friends, so that they may also come forward and assist us, for we have before us great anxieties as well as great encouragements. I think I have detained you long enough. My next duty to-day is a very agreeable one, and that is, to introduce to you Lord Pembroke and Lady Pembroke. (Applause.) Lord Pembroke has recently become a Governor of the hospital, and I am glad to think that he has done us the honour of paying us a visit to-day, because I believe he will be pleased with what he sees going on around him and that we shall get him frequently to come and join our Council. Lady Pembroke has kindly consented to give away the prizes—(applause)—leaving it naturally to Lord Pembroke to make a speech, which I hope he will do. I have now the pleasure of calling upon the Dean, Dr. Shaw, to read out the names of the prize-winners, and upon Lady Pembroke to distribute the prizes. (Applause.)

Dr. SHAW then read the list of Entrance Scholars, Prizemen and Medallists, and each recipient, on being handed his reward by Lady Pembroke, was heartily applauded by the spectators.

The following is a list of Medallists and Prizemen:—

OPEN SCHOLARSHIPS IN ARTS.—Frank Thomas Herbert Wood, Roan School, Greenwich, £100. Herbert Stanley Knight, Bancroft's School, Woodford Wells, £50. Herbert Andrew Watney, Trent College, Derbyshire, Certificate. Dental Students.—Osborne Black, Foyle College, Londonderry, £30.

OPEN SCHOLARSHIPS IN SCIENCE.—Henry Francis Bell Walker, Stockport Grammar School, and private study, £150. John Hunter Clatworthy, Guy's Hospital, £60. Gerald Russell, Guy's Hospital, Certificate. Harry Hunter Carter, Guy's Hospital, Certificate.

SCHOLARSHIP FOR UNIVERSITY STUDENTS. — Paul Norman Blake Odgers, Lincoln College, Oxford, £50. Greer Edmond Malcomson, Owen's College, Manchester, Certificate. Frederick Henry Parker, Pembroke College, Cambridge, Certificate.

JUNIOR PROFICIENCY PRIZES.—Percy Reginald Bolus, £20. Edwin Henry Britton Milsom and Neville Ivens Spriggs, equal, £12 10s. each. Kenneth Black, Certificate. Reginald Larkin, Certificate. Alexander Moxon Webber, Certificate.

THE MICHAEL HARRIS PRIZE FOR ANATOMY.—Alexander Moxon Webber, £10. Reginald Larkin, Certificate. William Leigh Maule Day and Lionel Henry Moiser, equal Certificates.

THE WOOLDRIDGE MEMORIAL PRIZE FOR PHYSIOLOGY. —Percy Reginald Bolus, £10. Neville Ivens Spriggs, Certificate. Edwin Henry Britton Milsom, Certificate.

THE HILTON PRIZE FOR DISSECTION (1899).—Harold Tipping and Alfred Herbert Edwin Wall, equal, £2 10s. each.

THE ARTHUR DURHAM PRIZES FOR DISSECTION.—First Year's Students.—Edward Crosby Peers, £5. Senior Students.—Alexander Moxon Webber, £15. Geoffrey Carlisle, Certificate. Frederick Rogerson, Certificate.

DENTAL PRIZES. — First Year's Students. — Gerald Hamilton Morris, £10. Samuel William Iles, Certificate. Second Year's Students (1899). — John Black, £15. Francis Wilberforce Garman and Harold Maurice, equal Certificates.

PRACTICAL DENTISTRY PRIZE. — Gerald Hamilton Morris and Arthur Henry Clogg, equal, £5 each.

SENIOR PROFICIENCY PRIZES.—Graham Scales Simpson, £20. Edward Cohen, Certificate.

THE TREASURER'S GOLD MEDAL FOR CLINICAL SURGERY.—Graham Scales Simpson.

THE BEANEY PRIZE IN PATHOLOGY (1899).—Caleb Thomas Hilton, £34. Frank Shufflebotham, Certificate.

THE RICHARD BREDIN PRIZE FOR CLINICAL STUDY.—Caleb Thomas Hilton, £25.

THE EARL OF PEMBROKE: Ladies and Gentlemen, I can assure you that I am very much obliged to Mr. Bonsor for the kindly way in which he has referred to the names of Lady Pembroke and myself in connection with our coming here to-day. I may say, first, that Lady Pembroke esteems it a great pleasure, interested as she has always been in hospital work, to come here on this occasion and give away the prizes at such an interesting institution as this venerable hospital (applause). I think I may, on her behalf, and on my own behalf, and perhaps on behalf of all those who are present, give our warmest congratulations to those gentlemen who have just received the prizes which Lady Pembroke has handed to them (applause). I hope that their winning the prizes will, in every case, be a precursor of great success in their profession in the future, and that amongst those who have received their prizes and certificates to-day there are many whom, in time to come, we shall hear of as eminent medical and surgical practitioners, destined perhaps, to make the world ring with their skill and their knowledge (applause). Then I think I ought to say one word to those who have competed, but not succeeded in carrying off prizes, and to them I would offer this word of consolation which comes from an old public school boy—that a great many successes in every branch of life have come to men who have never won a prize, and I anticipate that amongst those, too, who have not succeeded in winning prizes on this occasion there are some of whom we or our successors shall hear in the future. Then I am glad to hear that a great deal of good and useful work has been done by those who have not competed in these examinations, and I would also venture to congratulate them upon their year's work. Now, ladies and gentlemen, I am supposed to be addressing myself, in a great degree, to those who are

studying for their profession in this hospital, and I would venture to point out to them what may have been pointed out many times before, namely, what a great advantage, if I may use the term, they have over students who are studying for other professions. Students preparing for the law or any other profession are simply learning to make themselves proficient in the profession which they are going to adopt, but you have the advantage of doing actual, practical, useful work whilst you are learning more and more. I believe that in this hospital, where there are some six or seven hundred medical students, nearly one-half of them are engaged in practically carrying on the work of the hospital in every sort of capacity. As clerks, as dressers, in making researches, and in other ways, you are assisting the staff to carry on this great institution, and are thereby, even in your early years, doing an amount of practical work which is open to no other class of students in the world. So much so is this the case, and so valuable is your work here that I am informed that, whereas in olden days there was only one operating theatre in use in the hospital, and that was only used on two days in the week, now there are three in which work is daily done, and I understand that in the near future there will be two more. (Applause). This increase of work in the operating theatres could not be carried on were it not for the practical assistance given by a number of the students themselves. Then I am also informed that their help is extremely valuable in aiding the medical staff in the matter of research, in finding out the cause of disease and in carrying out the treatment prescribed, and this, whilst, of course, it adds to the experience gained by the students, is unanimously appreciated by the physicians and surgeons of the institution. I think the British public has fully and entirely recognised the immense value which the community, as a whole, derives from fully-qualified medical practitioners. It took them a very long time to find that out, but I do think they are fully alive to the fact now, and I think the experience of late years has shown how well the efforts which have been made by those who are interested in hospitals amongst all classes of society, have been responded to by the community at large. I may refer still further, perhaps, to that point a little later. I am sure that even in time of peace this progressive and good medical knowledge is greatly appreciated, but still more at the present time, perhaps, when one considers how useful that knowledge has been during the war now raging in South Africa. You, I think, in Guy's Hospital have done your full share towards showing what the medical profession can do out in South Africa (applause), where a very large contingent of Guy's men is at work at the present time. I am given to understand that something like one hundred doctors and nurses are out there at the present moment. Further, I believe that in the Yeomanry Hospital at Deelfontein the staff is largely a staff from Guy's, and that three of the members of Guy's visiting staff are on service there, while the valuable assistance rendered by the Army Medical Corps and the civilian medical officers have been fully recognised by those who know anything about their work in South Africa. I cannot trust myself to speak of the unfortunate remarks which have been recently published as to the doings of the Medical Staff of the Army Medical Corps out in South Africa at the present time, but I feel confident of this, that when the promised inquiry is held we shall find that both the members of the Army Medical Corps and the civilian medical officers, who have so nobly gone to the front to assist their brethren in the army, will be proved to have done excellent work, and that not one-fourth of the charges which have been recently brought before the public will be found to have the slightest foundation whatever. (Applause). The reports which are coming back from your representatives out there are, I believe, most satisfactory. I regret to say that many of them have suffered the ill-fortunes of war, and that two surgeons have died on the field of battle, whilst, I believe, six have succumbed to the terrible ravages of enteric fever which is so prevalent there. I understand that it is proposed to erect here in Guy's Hospital some permanent memorial to those who have lost their lives in the excellent and noble work which they volunteered to undertake. (Applause). A large institution like Guy's Hospital, ladies and gentlemen, cannot, as Mr. Bonsor has said, be carried on without the assistance of the public. Well, as I have stated, the public has, with almost an unprecedented degree of generosity during the past few years, come forward in response to the appeal that has been made on behalf of this great and noble institution. But, ladies and gentlemen, we must not stop there. There are few hospitals, I may say there are no hospitals in existence here in England that can carry on their work without the voluntary contributions of the public, and it is the business of all who are interested in hospitals to urge the public to continue those contributions. But there is one thing that the public demand before we can get them to contribute, and rightly so, and that is thorough efficiency in the management of these hospitals. There are always, and always have been amongst mankind, a certain number of individuals who seem to consider it their duty to pick holes in the management of every public institution. An epidemic —if I may call it—of fault-finding rages at times, and I think we have been suffering from it during the last two or three years. Let us hope it will blow over. It causes a great deal of pain and a great deal of anxiety to those who are responsible for the management of such institutions. But there is no doubt about one thing, that while it causes pain and anxiety, and, may be, does harm to the subscriptions which otherwise would come in, it puts the Committee of Management on their mettle, and that is the only redeeming point, I think, to be found in these perpetual charges. It puts, as I have said, the Committee of Management on their mettle, and makes them determine that no possible flaw shall be

found in the management of such institutions. I think there is no body of men who have realized this to such an extent as the Governors of Guy's Hospital—(applause)—for they have shown a determination, and are carrying it out, to put this charity into the highest possible state of efficiency with every modern improvement that invention can suggest. When we passed from the Governors' Court-Room on our way here to-day, one could not but be struck with the amount of building work which is going on. Mr. Bonsor referred to the Nurses' Home, which will be such a benefit to this institution, to the Laundry, which also will be a great benefit, and to the renovation of the wards which is going on. Then there is that new department in connection with the Röntgen rays which will be of the most valuable assistance to all who are officially associated medically or surgically with the institution. In fact, improvements are going on all over the hospital, and I think this shows that the Governors, who are alive to the possible criticisms which might be passed, are alive also to the claims which the modern state of society makes upon an institution of this sort. Well, ladies and gentlemen, I will only say one word, in conclusion, to those who are occupying the position of medical students, and I will ask them to remember the responsibilities which rest upon them now in the practical and good work in which they are engaged, and to remember also the great responsibility which will rest upon them in the future. And I would urge upon them not only a due attention to their studies, which is a thing that everybody is urging upon every student, but I would urge upon them particularly the necessity of thoroughness in their work, thoroughness being, in my opinion, perhaps the most important element in the study of any branch of science. If you thoroughly master the rudiments of your science, if you work thoroughly at the beginning you will find everything as you advance much more easy. The future is before you, and it is a future in which I hope you will all succeed. At the present time, and in the immediate future, you have great responsibility from the fact that you are looking after many hundreds and thousands of human lives, a large number of them belonging to the poorest class of society. Your work will give you a feeling of satisfaction, an inward consciousness of having done your best, and will, I hope, in the future bring with it the material rewards of a good and successful practice. But there is one thing which I think you must ever bear in mind, you who are studying here now, and that is, that you received your medical examination at Guy's Hospital. You will, I trust, maintain the grand traditions of this hospital throughout your lives, and never forget that you are Guy's men. (Applause.)

Dr. Frederick Taylor (Senior Physician): Ladies and Gentlemen, I have to ask you to accord a very hearty and enthusiastic vote of thanks to Lord and Lady Pembroke for coming down to Guy's Hospital on this occasion to distribute the prizes. I do think we are to be congratulated on having their presence here this afternoon for that purpose. Mr. Bonsor has told us that this is Lord Pembroke's first visit here, and I think we are also to be congratulated on the fact that the Medical School of Guy's Hospital, which, of course, is the occasion of our being here to-day, should have the primary honour of meeting with Lord Pembroke, and that his lordship, on this his first visit to Guy's Hospital, should have an opportunity of seeing the Medical School in all its glory and in all its collective strength. You will, I am quite sure, desire to convey your thanks to Lady Pembroke for the very gracious way in which she has distributed the prizes to the successful candidates to-day, and I trust that these latter will go back to their homes more than ever determined to carry on the successful work which they have so successfully begun. I think we must also thank Lord Pembroke for the excellent address which he has just given us—an address of congratulation and encouragement and advice to the students of this hospital. His lordship has shown how the medical students in the Medical School are of the greatest assistance to the working of the hospital. That, I may say, is a point on which the medical staff and the Medical School generally are just a little bit sensitive, because, as you know perfectly well, criticisms do appear occasionally, and these make us feel that we should be careful in what we do in our relations with the medical students. Of course, medical students cannot do without a hospital; that is a primary fact. No civilised country could allow that its medical men should receive a diploma certificate without having first gained that knowledge of the treatment of disease, which can only be really obtained nowadays within the wards of a hospital. At any rate, a Medical School undoubtedly is needed in order that the students may learn what they so much require afterwards in the practice of their profession. Lord Pembroke, as we have just heard, has pointed out that this is so. He has referred to the efforts of the students in various ways, and there are accumulated volumes upon volumes of records by these students which possibly at no distant date may prove, some of them, of very great value in regard to the treatment and cure of patients. The students also render a great deal of mechanical and manual assistance to the medical staff in connection with the providing and use of antiseptics, instruments, etc., necessary for the hospital. The importance of our relations, of course, to South Africa has already been alluded to by Lord Pembroke. We have sent out there a number of our older students, and we all regret the illness and deaths that have taken place amongst them. I can speak, on behalf of the Staff, of the useful work which has been done by them. The work of those Guy's men has been thoroughly well and satisfactorily done. With these few remarks, ladies and gentlemen, I have to ask you to record a hearty vote of thanks to Lord and Lady Pembroke for their kind attendance here this afternoon. (Applause).

Dr. Stevenson (Senior Lecturer in the Medical School): Ladies and Gentlemen, it is my pleasing duty on this occasion to represent the Medical School, and to second this vote of thanks which I have no doubt you will heartily accord to Lord and Lady Pembroke for their kindness in coming amongst us and distributing the prizes. It is particularly gratifying to find Lord Pembroke among us, and now for the first time taking an active interest in the hospital, for I am old enough to remember, at a similar time to the present, the period of the Crimean War, the great interest displayed by a distinguished ancestor of Lord Pembroke in looking after the medical interests of our soldiers and sailors. (Applause.) I had intended to have occupied you about one minute in speaking of the relationships of the Medical School with the Hospital, but my colleague, Dr. Taylor, has very properly said all that I could have said about that. The Medical School is really a twin sister of the Hospital, and I think neither twin could exist without the other. (Hear, hear.) Ladies and Gentlemen, I will only ask you in conclusion to cordially pass this vote of thanks to Lord and Lady Pembroke for their presence here to-day. (Loud applause.)

The Chairman: I think, ladies and gentlemen, I may take your applause as carrying this vote of thanks unanimously. (Renewed applause.)

Lord Pembroke: Ladies and Gentlemen, I beg to thank you for so kindly and cordially passing this vote of thanks to Lady Pembroke and myself, and to thank Dr. Taylor and Dr. Stevenson for their kindly references. As a matter of fact, Dr. Stevenson's remarks on the subject of the Crimean War were present in my mind when I was thinking of the subject of the complaints as to the medical arrangements in connection with the present war. It is wonderful how history repeats itself. Although a great many attacks were made on the War Office, and very justly so, at the time of the Crimean War, yet history will tell us that the Secretary of State for War then, and the Secretary of State for War now, both did their absolute best to try and remedy any defect that might be found. (Applause.) And I hope the public will continue to trust in those who are responsible at home to do their absolute best to remedy any defects that may be proved to exist, and to carry out any valuable suggestions which may be made by anybody who thoroughly understands the subject. It has been a very great pleasure to Lady Pembroke and myself to come here to-day, and we thank you for your cordial reception. Reference has been made to the fact that this is the first time I have been able to come here. I warned my friend Mr. Bonsor, when he proposed my name as a Governor, that so many were my duties at the present time that it would be very difficult for me to find time to do any work at Guy's. I do hope that I shall have more time at my disposal in the future, so that I may come here and render you any little assistance that it may be in my power to do. (Applause).

This concluded the interesting proceedings.

The Biennial Dinner.

The Biennial Dinner for "Past and Present Students of Guy's Hospital, and their Friends," took place at the Whitehall Rooms, Hotel Metropole, on Friday, July 6th, and owing to the combined efforts of Mr. Symonds as hon. secretary and chief organiser, and Mr. Higgens as chairman, it proved a great success. The total number arranged for at the dinner was 242, and very few vacant chairs were seen. Most of the staff of the hospital, including the consultants, were present, and a large number of old Guy's men. The dinner was excellent, and excellently served, and everyone looked happy and contented. It would, perhaps, have been better if some of the speeches had not been quite so lengthy. In such a meeting so many friends come together who are otherwise separated by long intervals of time, and though strict silence is by no means maintained during the speeches on such occasions, yet there is always some considerable constraint. Dinner completed, Mr. Higgens (the Chairman) rose to propose the toast of "The Queen," which was responded to by the singing of the National Anthem. Then followed the toast of "The Prince of Wales, as President of the Hospital," also proposed by the Chairman.

The Chairman then rose for the third time, to propose the toast of the evening—"Prosperity to Guy's Hospital and the Medical Staff."

Mr. Higgens said, in proposing this toast, he should like first of all to pay a tribute of esteem to one who had only lately so suddenly left us; he referred to Mr. Davies-Colley. He was a man of sterling worth without gilt or veneer; he was the very soul of honour, conscientious to a fault, he had no consideration for self in following the path of duty, he was incapable of anything mean or selfish, he was mentally broad-minded. He was slow to speak, but when he spoke on a subject he left it threadbare—there was little more for anyone else to say. His death had caused a gap in the hospital which nothing could fill, but there was even a greater gap among those more nearly and closely attached to him, and he thought it would be right and proper in a large gathering of Guy's men like this, that they should pass a vote of compassion to his wife and family for their great loss. He had to couple this toast with the name of Mr. Bonsor, and, in fact, the prosperity of Guy's *was* coupled with his name, it was most closely connected with him; he wanted everyone to look at Mr. Bonsor, he was one of the best that ever lived, he was the most popular man inside and outside of Guy's. He wanted to address those of his time, before his time, and afterwards, and to compare the conditions of things as they were and as they are now; he knew comparisons were odious, but he liked to be odious. In his time, and before his time, there existed nothing of the present friendly relations between Treasurer, Staff and Students. Visiting the Treasurer was regarded as terrible as visiting the police court. Amusing references then followed as to the condition of the hospital in past days—for instance, the washing basins, if you pulled the stopper out of the little

washing basins at Out-patient's you were nearly poisoned by the smell. Mr. Lushington certainly did have the drains attended to, but to Mr. Cosmo Bonsor belongs the credit of establishing the present friendly relations between the Staff and the Governors. All can see what he has done. He thought the new buildings, with the long windows reaching nearly to the ground, were not exactly adapted for ladies' sleeping compartments. He believed he remembered reading in the *Guyoscope* that front seats in Dr. Starling's laboratory had been booked weeks beforehand, at the time when the new buildings were first occupied by the nurses. Owing to the liberality of Mr. Raphael, a new nurses' dormitory was to rise up before long, where at present all looked bricks and chaos. The front surgery had been cleaned up, enlarged and improved since Mr. Bonsor had been there, and still greater things were to happen. Cornelius and Astley Cooper are now models of sanitation and asepticity. He was really sorry for the bacteriologists; they would have no fields to exploit; the microbes would now get no rest at all; they got carried about on salembroth or drowned in lysol or carbolic. All these changes had been brought about by Mr. Bonsor. He is the friend of us all. Mr. Bonsor had laid down a monument of himself in the colonnade. Mr. Bonsor knows all the staff, the students, the sisters and the nurses too. He must also associate with these changes the name of Dr. Perry. Dr. Perry came to us as an outsider, and came against the will of some. It was perhaps a good rule not to accept anyone for the Staff who was not a student of Guy's, but in the case of Dr. Perry its non-observance had worked admirably. As an administrator he was pre-eminent. If it were possible, his capabilities were wasted at Guy's, for he ought to have been Chancellor of the Exchequer. The School was in the usual flourishing condition, and in quality was second to none. The teaching compared well with that of any other hospital. In sport, Guy's were at present out of it—no trophy graced the walls of the smoking-room—but they must hope for better luck in the coming season. Reference was made to the Guy's men in South Africa, and to the losses we had sustained. A special message of greeting had been sent to them from the hospital at Deelfontein, in which the nurses wished to be included. On the whole, he thought there was no profession like the medical, and it was certainly not overcrowded at the present time. He had to propose the health of everyone, and he coupled with the toast the name of Mr. Bonsor.

Everyone then drank to the health of Mr. Bonsor, and gave him musical honours to the tune of "He's a jolly good fellow."

MR. BONSOR responded. The chairman had dealt so fully with domestic details that he felt compelled to touch on each point. When he described in such detail the condition of the washing basins, everyone felt that their chairman was thoroughly at home. From his reference to the long windows of the new buildings and the seats advertised in some obscure journal, he must conclude that the chairman was one of the disappointed ones. If it had not been for the chairman, he was prepared to take a serious view of the subject. After all, he thought they were pretty good fellows. The Governors and Medical School were on excellent terms, and the Governors were thoroughly interested in the Medical School. The chairman had told him a lot of things he intended to talk about—he had not mentioned one of them—he says he forgot all about them. He (Mr. Bonsor) had made a lot of notes, and now they were no good. He said he was going to defend the Dental School. He had said absolutely nothing about it. He (Mr. Bonsor) thought it was a splendid addition to the Medical School, and had done much for the hospital. Guy's Medical School was the only school which was absolutely independent of the hospital. The attacks which had been lately made upon it were not worthy of consideration by a body of educated men. He thought the greatest praise was due to Dr. Perry as an administrator; when Dr. Perry came, the hospital had gone to sleep—he woke it up. He and Dr. Perry had worked together as partners, and he thought they had made the hospital the first in the world. He felt he ought to say something about the sisters, the nurses, the servants, and God knows whom else. He thought Guy's Nursing Staff was the best in the world. Then there were the past and present students. He was afraid, judging from the chairman, the past students were a wicked lot; the present students gave him no trouble at all; he thought they thoroughly understood one another, in fact, they were simply so many boys together. His work as Treasurer was an exceedingly pleasant one. The time he devoted to it was playtime.

On the Treasurer resuming his seat, "Auld Lang Syne" was sung by everyone.

MR. HOWSE then proposed "The Imperial Forces." He referred to the troubles in China, and expressed the fear that Dr. Poole may have been sacrificed in the massacres that had probably taken place at Pekin. The war in South Africa had called forth almost unparalleled patriotism and loyalty. Besides a considerable Guy's contingent to the medical services, they had also contributed a few men to the volunteer forces, and they had their losses. He defended the alleged inefficiency of hospital accommodation, and pointed out that it was not unknown for an epidemic in a city like London to tax the hospital accommodation beyond their capacities.

SURG.-GEN. MUIR, C.B., responded, and defended the Army Medical Service and their work in the war. He thought they had done their best, and would come out of it as well as they could.

The chairman then read the telegram from Deelfontein—"Hearty greetings from medical and nursing staff of Deelfontein."

Dr. TAYLOR in proposing "the Consulting Staff," referred individually to Sir Samuel Wilks, Dr. Pavy, Mr. Bryant, who has recently lost his son in South Africa, Dr. Pye-Smith, and Dr. Goodhart.

Sir SAMUEL WILKS said that his mind went back to the Biennial Festival he attended years ago, and he looked at Guy's as it was then and is now, and he asked himself, had

he been disappointed, were his hopes blighted? No! emphatically no. When he went to Guy's last Wednesday, his thoughts must have been very different from those of most others. His mind went back to long before the time mentioned by their President—more than half a century. He could hardly recognize that he was in the same place. Instead of old decrepit walls and cottages that he well remembered, he saw those splendid buildings—it was like a transformation scene. He asked himself what it embodied, there could only be one answer, it was the advancement of medical science, coupled with the enthusiasm which has always characterised Guy's Hospital. He could go back fifty years and look at the old place, it was like a hovel being converted into a palace, and as regards the changed system of government, that was more remarkable still. In those days Guy's was a private hospital, and the trustees were the governors, and they carried out the administration thoroughly, but it was a despotic government. The medical staff had no voice whatever in the constitution. But there was a revolution. The nursing affair started it. They came one day and found a system of nursing in force upon which the medical staff had never been consulted. The governors were acting within their rights no doubt, but what he always said was that the two should be united with a common object. That had now been realized, they were amalgamated and he was the embodiment of this change, for he is a member of the medical staff and a governor at the same time.

Dr. Pavy then also responded briefly for the "Consulting Staff" in a few well-chosen words.

Loud cries of "Pye-Smith" were then heard from all parts of the room, and in response Dr. Pye-Smith rose and said he should like to remind those present that there were brave men before Agamemnon, and good treasurers before Mr. Bonsor. He referred to the great virtues that Mr. Thomas Quin concealed under a somewhat brusque manner, and Mr. Lushington had admitted that he had made a mistake in a manner which they all could not help admiring. The changes which had taken place were undoubtedly for the good of the place, but however much better the work might be done, nothing could take from them the honour and glory of having walked the quarter-deck of that colonnade, of having been a worker in the great work of Guy's Hospital and the Medical School. Of that nothing could deprive them.

At the conclusion of Dr. Pye-Smith's speech there were again loud cries from all parts of the room, this time for "Goody," to which Dr. Goodhart responded in a short amusing speech.

Dr. Savage then proposed "The Chairman." He said he intended to show what a short speech should be. It was thirty-four years since he first made a speech at Guy's Biennial, and on that occasion it was the last of the evening. He spoke as house-surgeon. For thirty-eight years he had been associated with the Chairman. Most of those present knew him, not as well as he did, but they knew him, and that was enough. "Higgens is a man we all respect, we all can trust, thorough in everything, whether he be riding to hounds or winning a donkey race. I feel that to praise him before you is unnecessary. From my heart I wish him every prosperity."

The Chairman, in reply, said he wished he could recognise himself in one-half the pretty things Dr. Savage had said of him. He would try and give them his own views of himself. His own motto throughout life had been to go straight and fear nothing. He thought he had some amount of bull-dog courage. Mrs. Higgens called it *pig-headedness*, except when it came out in their little daughter, and then it was called *firmness*. He had been successful in his profession beyond his utmost hopes. He owed something to himself, but he owed ten thousand times more to his friends and fellow-students. If this dinner had been a success, it was nothing to do with him, but all to do with the secretary, Mr. Symonds. He had thrown his whole heart and soul into it, and had worked hard for it, and all would agree that he had made it a thorough success. He then called upon all to drink to the health of Mr. Symonds.

Mr. Symonds responded in a few words, and suggested that the duties should in future devolve upon some younger member.

The assembled company then broke up, after having spent a most enjoyable evening.

The following reply was received from the Yeomanry Hospital in South Africa to the message: "Heartiest good wishes from Guy's Biennial Dinner to Medical and Nursing Staff.—Higgens":—

"Cape Town, 11th July.

"Thanks Biennial Greetings.—Washbourn."

The cable was the suggestion of the Chairman, and was sent at his expense.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants in Medical Wards.—Messrs. P. T. Manson (Dr. Taylor); A. Densham (Dr. Hale White); E. Shelton-Jones (Dr. Pitt); S. Hodgson (Dr. Perry).

Ophthalmic Dresser.—Mr. S. J. Ormond (Mr. Higgens) (August).

Surgeons' Dressers.—Messrs. J. E. Collins, F. A. Beattie, E. Bigg, F. D. S. Jackson, S. Child, G. H. H. Manfield (Mr. Howse); W. M. Robson, M. A. Collins, J. A. Andrews, G. Evans, R. C. Lawry, H. P. Wiltshire (Mr. Lucas); F. C. Wetherell, J. Evans, H. W. Brown, E. G. Allport, W. J. Davies, W. O. Roberts (Mr. Golding-Bird); M. J. Rees, A. Wylie, A. C. H. Gray, C. Tessier, G. T. Collins, D. H. Trail (Mr. Jacobson).

Externs (August).—Messrs. J. D. Bridger, R. Thompson, E. I. Claxton, H. Davies-Colley, N. F. Ticehurst.

Passim.

IT is difficult to refrain from lodging a mild and gentle protest against the heat of the weather. The Borough is hardly an ideal spot for a hot summer's day, even when one can loll in the park and listen to the cooling chatter of the fountain. Our lot at present has fallen in anything but a pleasant place, and the very numerous and fatiguing journeys at all hours of the day and night into the heart of Bermondsey, make simple existence a wearisome toil and inevitably tinge one's views of life with a sombre hue. The huge medical wards with their ample ventilation and thick walls manage to keep comfortably cool, and if one could spend the day in "Hunt's House," perhaps our tendencies would be less suicidal; but doomed to dwell in that noisome little den in the college reserved for externs, we naturally take a somewhat jaundiced view of the situation, and long for thunders, lightnings, and earthquakes—anything to break the fearful monotony of this intolerable heat.

THE Lords of the Admiralty have decided to establish a system which will enable them in times of emergency forthwith to secure the services of qualified medical men. The basis of the scheme is somewhat similar to that of the Naval Reserve. The aspiring candidates undertake to engage for general service, and express themselves ready to proceed on duty abroad whenever required to do so. In order that there may be no delay when the men are required, the Lords Commissioners invite duly qualified practitioners, who must be under forty years of age, to enter their names on a list of volunteers to be kept at the Admiralty. Then if there be any need of surgeons, these gentlemen will be called upon for at least six months' service anywhere, with a liability of immediate dismissal for misconduct or incompetency, and a promise of two months' notice and two months' pay when their services are no longer required.

IN return, these gentlemen will rank with, but subordinate to, surgeons in the permanent service, will receive a grant of £20 towards uniform, and pay at the rate of (full-pay) 15s. 6d. a day, half-pay (sickness and extra leave) 10s. a day, with lodging and ration-money when employed on shore. Should they be so unfortunate as to be killed in action, their widows will receive each a pension of £80 a year, with allowances for children, while in the event of their being "drowned, etc., by Acts of the Enemy," the pension and allowances are proportionately reduced. No pension or gratuity will be given should the surgeon lose his life when "carrying on the ordinary duties of the service." On the whole, the regulations seem equitable and should appeal to those men who like an occasional roving life, in the finest service in the world.

IN the *Journal of the Universities Mission* there is a very amusing appreciation of the work of Mr. Robert Howard, of the Likoma Mission. He primarily practices his profession on Europeans and Africans, and has so successfully won the hearts of the native population that it became necessary to evict one female patient from the hospital, as she refused to leave and announced that she should settle down there for good. In the intervals of "going round" he builds spare hospitals and dispensaries, besides doing all the repairs to the missionary fleet. When time hangs heavy on his hands, he clears roads and plants avenues of trees, and in addition, regularly fulfils the duties of village policeman on all riotous occasions. His only fault—and this from his own point of view could hardly be so considered—lies in his habit of looting all the most desirable stores, and transferring them to the hospital buildings. Veritably an admirable Creighton.

WE have received, without any explanatory letter, a little pamphlet entitled, "Plays and their Supervision," which contains a speech by Samuel Smith, Esq., M.P., and the reply of the Home Secretary. Why it was sent to us we have not the faintest knowledge, and we are almost equally in the dark with regard to the party which sent it. Since, however, Mr. Smith's name appears in capitals and the Home Secretary's is relegated to lower case, we suppose that we are indebted to Mr. Smith's side for this little book. We therefore take this opportunity of thanking him for his thoughtfulness, but at the same time we must repeat that we fail to see the connection between the GUY'S HOSPITAL GAZETTE and the question of licensing plays.

THE *Evening News* has an obviously inspired paragraph on Professor Cunningham, who, as everybody knows, has been placed upon the "Hospital Scandals Commission." We reproduce the following:—"In 1884, when the Trinity

College Professor, Dr. MacAlister, transferred his services to Cambridge, Dr. Cunningham was elected as his successor. The Trinity Medical School was then a wretched building, but in a very few years Professor Cunningham forced the slow-going University governors to build one of the finest schools in the kingdom. "Dan," as he is familiarly called, has a marvellous influence over the students. A glance from his eye is more effectual in quelling disorder than a threat of the sjambok. He is greatly respected and liked, as well as feared. Dr. Cunningham's "Manual of Practical Anatomy" is one of the best treatises published on that dreary science. He is a dab on skulls, and has a museum in which one may trace the gradual rise of intelligence from the ape to the Frenchman. According to Dr. Cunningham, the French are the most highly civilised people on earth, as shown by their facial angle." Many of us have met Dr. Cunningham on the Embankment, but we never called him by his pet name there.

THE second Garden Party given by Mr. Cosmo Bonsor was an unequivocal success. The weather, out of London, was simply perfect, and the magnificent grounds at Kingswood Warren appeared at their best. The nurses gave a quaintly picturesque touch to the scene, and as we wandered at sweet will we were continually met by little groups of the prim uniform with an occasional leaven of masculine grey flannel. Mr. Bonsor's request that the nurses would take *carte blanche* in the picking of flowers was very thoroughly appreciated, and on the return journey to town it was evident that the feminine taste for flowers was satiated to the extreme. Altogether, the afternoon was extremely enjoyable, and when the matron's warning bell directed an exodus to the station, everybody sighed and walked slowly as if loth to end the day.

WE have received a letter from Mr. W. T. Milton, who represents Guy's in No. 9 General Hospital, Bloemfontein, in which he gives some further account of the late H. A. Bryant. "We buried poor Bryant to-day—his death was very unexpected and a great shock to all of us. He had been ill with enteric fever for nearly three weeks, and had been removed to the Volk's Hospital, close to No. 9, as it was thought he would be more comfortable there than under canvas. His temperature had come down, and it was confidently thought that he had turned the corner, when he suddenly shewed unmistakable signs of perforation of the intestine, and died in a few hours, operative treatment being out of the question. His remains were conveyed on a transport wagon to Bloemfontein Cathedral, where a short service was held, and then to the burial ground. Almost the whole of the staff of No. 9 were present, and six of the civil surgeons attached to the hospital acted as pall-bearers, and lowered their fellow-worker into his last resting place. Then the notes of the 'Last Post' rang out, and we returned in silence to the camp over which such a gloom has been cast by his untimely death."

WHILE we were revelling in the sunshine at the Prize-giving, Mr. Steward was relinquishing his last claims to bachelordom in Birmingham, and he is now back at the hospital with the distinction of being the most newly-married member of the staff. Our present to Mr. Steward on this occasion was a silver candelabra with an engraved inscription on the plinth, and although we may incur somewhat the reproach of crying our own wares, we must admit that it was of very handsome design, and altogether a fitting testimony to the universal good-fellowship in which Mr. Steward is held.

IN the published list of the Junior Teaching Staff appointments, we notice that Mr. R. H. J. Swan has been appointed Demonstrator of Anatomy, *vice* Mr. Steward, resigned. We congratulate Mr. Swan on his well-merited and honourable post, and we hope he will have as successful and enjoyable an experience as he has had in his house appointments. Mr. Swan is of such a recent age that his hospital career is well known to most; probably, however, not the least valuable factor in his armament will be the possession of the "Soccer" Hospital Blue, with its inherent sympathy for sport, which wins the heart of the first year's men.

LAST Thursday the whole of the Borough and South Bermondsey tied itself up with bits of coloured paper, and went round collecting money for the Widows' and Orphans' Fund. We at the hospital touched the skirts of the procession as it swung into Tooley Street by way of Joiner Street. It was a truly wonderful sight, replete with kharki heroes and naval brigades, with triumphal cars, some emblematical of local trades, and some representing what-

ever you pleased to call it. The bands, fortunately, were few indeed, for in quality they were execrable; the spectators were many and the collectors ubiquitous. From the Borough point of view the whole affair was a great success, and was provocative of much ardent discussion, after which the disputants came into the front surgery for repairs.

Any old Guy's man who has control over votes for the Royal Medical Benevolent College, Epsom, should send his proxies to Mrs. Anderson, Bexley House, Deal, on behalf of her son, Graham Alfred Langford Anderson. By so doing he will benefit not only a case which demands help on its own merits, but he will also help the son of an old Guy's man, and thus act up to the spirit of our hospital motto. Mr. L. E. Anderson, M.R.C.S., L.S.A., of Hampton Hill, Middlesex, died in 1893, when only thirty-three years of age, leaving a widow and two children. It is on behalf of his son that we ask for votes. He has already secured a hopeful number, but the fact that he is only eligible *for one more election* makes it imperative that all the help that can be possibly given, should be forthcoming. We sincerely trust that Guy's men will respond to this appeal and will make a note of the date of the election, which is in May, 1901.

The Sixty-Fifth Annual Report of the British Medical Benevolent Fund shows a good record of work done, both in the annuity and grant departments. In the former, the total income received was some two thousand pounds, and nearly the whole of this was disbursed to the annuitants. In the grant department the annual subscriptions and donations show a marked falling-off, the cause of which is not far to seek, and the committee found themselves obliged to transfer an annuity legacy to the grant funds. The amount of distress and poverty with which this society has to deal is simply appalling, and the executive appeals for financial help in alleviating the mental and bodily sufferings of the medical "shabby genteel" who have sunk below the level.

Universal regret is felt in the hospital at the impending resignation of Sister Clinical, after many years of sterling work on the Nursing Staff. Sister Clinical (Miss Hermann) entered Guy's in 1886, and a year later was appointed sister of the then Accident ward. Here she remained some three years, and was then transferred to Stephen ward. A year later Miss Hermann left the hospital, and after doing temporary work, crossed the Atlantic and put in some nursing in South America. Returning to Guy's in 1894, she was appointed sister of Mary ward, and two years later was transferred to Clinical, which she has held ever since. We wish Miss Hermann every success in the new life upon which she is entering.

Nursing News.

Matron's Office.

The following Probationers have been successful in passing the Probationers' Examination in Medicine:—Probationers B. Alcock, A. Allen, Anness, Backett, Ball, Bishopp, Blasson, Bolton, Boyle, Burrow, Bryan, Cameron, Chittock, Clark, Colville, Cook, A. Collins, Conolly, Cotterell, Coleclough, Cope, M. Creasy, E. Crowe, F. Crowe, M. Davis, Dingwall, Densham, Dixon, Earp, G. Field, Guthrie, Hecks, Hembling, Hooper, Hutton, Iszard, Jackson, Lavy, Layng, Layton, Leslie, Lewin, Lightfoot, Lowenthal, Manning, Milman, Micklethwait, Morrall, Neale, Perriam, Pickles, Powell, P. Ray, A. Rogers, M. Rogers, Robertson, Russell, Savage, Seville, Stokes, Sutton, R. Thompson, Towsey, Tweedie, Walker, Walter, Weller Wood, Yates.

The second Garden Party at Kingswood Warren took place on Monday, July 9th. The guests, numbering about 120, left London Bridge, South-Eastern Railway, in a special train at ten minutes to two; Mr. Bonsor travelling down with them. On arrival at Kingswood Warren, the party proceeded to walk or drive up to one of the terraces in front of the house where Mrs. and Miss Bonsor were awaiting them.

The weather was delightful, and after light refreshments had been served, some of the guests wandered through the beautiful woods, some visited the church, farm, garden, greenhouses and stables, and others sat under the trees listening to the band on the lawn, played croquet, or tennis, or went over the house, where every room was thrown open by the hostess.

At a quarter past five, a cold collation was served in a large marquee in front of the house, and at half past six Mr. and Mrs. Bonsor and family accompanied their guests to the station, many of whom had their arms full of lovely flowers from the garden and heather and bracken from the moors. As the train left Kingswood Warren, hearty cheers were given to Mr. and Mrs. Bonsor, and Guy's was reached, after a most pleasant afternoon, at half-past seven.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Taylor.

Mary	38.	Multiple serous effusions. ? Tubercular.
	39.	Phthisis. ? Tubercular laryngitis.
	41.	Transverse myelitis.
	43.	Hemiplegia. Hemianæsthesia. Mitral stenosis.
	44.	? Malignant growth of liver.
	45.	Hysteria.
	48.	Continued pyrexia.
	49.	Post diphtheritic neuritis.
	50.	Hemiplegia. Hemianæsthesia.
Philip	23.	Pleuro-pneumonia.
	24.	Post-diphtheritic neuritis.
	25.	Phthisis.
	26.	Phthisis.
	27.	Phthisis. Tubercular peritonitis.
	28.	Phthisis. Pneumothorax.
	30.	Mitral stenosis and regurgitation. Tricuspid regurgitation. Pulsating liver.
	32.	Tubercular peritonitis.
	34.	Chronic interstitial nephritis.
	35.	Pernicious anæmia.
	36.	Sycosis. Eczema.
	37.	Chronic interstitial nephritis.

Cases under Dr. Hale White.

Mary	13.	Exophthalmic goître.
	14.	Phthisis.
	16.	Œdema. ? Cause.
	19.	Acute rheumatism.
	21.	Pleuritic effusion.
	22.	Migraine.
	23.	Empyema.
	24.	Floating kidney. ? Cerebral tumour.
Cot	54.	Diphtheria.
Philip	1.	Appendicitis.
	3.	Enteric.
	4.	Carcinoma ventriculi.
	6.	Secondary sarcoma of mediastinum.
	7.	Hemiplegia.
	13.	Mitral stenosis. Tricuspid regurgitation.
	14.	Meningitis.
	16.	Rheumatism. Lobar pneumonia.
	17.	Acute rheumatism. Aortic and mitral disease.
Philip	19.	Morbus cordis.
	20.	Pleurisy with effusion.

Cases under Dr. Pitt.

Mary	25.	Nephritis.
	26.	Purpura.
	27.	Diabetes insipidus.
	28.	Constipation.
	29.	Growth of colon.
	30.	Movable kidney. Hæmaturia.
	32.	Renal calculus. Cystitis.
	34.	Acute rheumatism.
	35.	Eczema.
	36.	Pleuritic effusion and ascites.
Cot.		Rickets. Fits. Left hemiplegia.
Stephen	21.	? Insular sclerosis.
	22.	Right pleuritic effusion.
	23.	Hæmaturia.
	24.	Acute rheumatism. Mitral incompetence.
	25.	Bronchitis.
	26.	? Enteric.
	27.	Appendicitis.
	28.	Enteric.
	29.	Right pleurisy.
	30.	Pneumonia.
	31.	Lead colic.
	32.	Malaria.
	33.	Aortic incompetence.
	34.	Diabetes mellitus.
	35.	Gastric ulcer.
	36.	Pleurisy.
	37.	Pleurisy.
	38.	Nephritis.
	39.	Carcinoma of stomach.
	40.	Pneumonia.
Cot.		Pneumonia.

Cases under Dr. Perry.

Mary	1.	Ulcerative colitis.
	2.	Pericarditis. Mitral stenosis and regurgitation.
	3.	Carcinoma mammæ. Secondary deposits in lung.
	4.	Pericarditis.
	6.	Abdominal tumour. Hydronephrosis.
	8.	Chronic peritonitis. Ascites.
	12.	Cerebral tumour.
Stephen	4.	Lobar pneumonia. Pericarditis.
	6.	Bronchitis and emphysema.
	7.	Lobar pneumonia.
	8.	Phthisis.
	12.	Mitral stenosis and regurgitation.
	13.	Typhoid.
	14.	Chorea. Mitral stenosis and regurgitation
	15.	Cirrhosis.
	16.	Aortic incompetence.
	20.	Chronic peritonitis. Ascites.

With the Army Medical Corps in South Africa.

(By Our Special Correspondent.)

(Published by permission of the Director-General of the Army Medical Service.)

Section of Field Hospital, 19th Brigade,
Marseilles,
Orange River Colony,
Ascension Day and Queen's Birthday, 1900.

We're all in such splendid spirits to-night that I must write a letter before turning in. Firstly, we've been allowed to drink the reserve ration of rum in Her Majesty's honour, and have shouted ourselves hoarse first. Secondly, we've done a good march of fifteen miles to-day before two o'clock, and have reached the railway again and the headquarter's column, Lord Roberts being at Vredeport, three miles down the line, where the station, water-tank and railway were blown to smithereens by those mischievous Boers two days ago. Thirdly, we have splendid news in to-night's orders. We are to march sixteen miles to-morrow to the Vaal, presumably westwards—as Vereeninging must be thirty miles off on the railway to the north. French and his cavalry have crossed the Vaal to-day. Behind us—seven days behind us—the Highland Brigade are to enter Lindley to-morrow. Rundle and his eighth division are about at Senekal, and Brabant at Ficksburg. In Natal they say Buller cannot have more than 2,000 Boers against him at Laing's Nek, the rest of the enemy being supposed to be preparing for a stand round Johannesburg and Pretoria. To our west, Methuen is at Bothaville, Hunter at Christiania, and Mafeking—most gallant little Mafeking—has relieved itself by the slaughter of twenty-five and capture of the rest of the attacking force, most of the Boers having sloped off eastwards.

We are all delighted at B.P.'s promotion. We only miss news of Carrington. I give you this summary of news to show you the state of affairs as we enter what seems to us to be a new and last phase of the campaign, and to leave you to imagine our joy at hearing it all after wandering through the veldt without any news whatever for ten days since leaving Kroonstad. We mourn, however, the absence of our letters, which we had hoped to meet here at the railway, and on behalf of the patients, in case we have an action of any magnitude, we mourn deeply the absence of our Field Hospital, as Captain Greich and I are the only officers left to run this Bearer Company and section of a field hospital between us. If there were an action we should have to go collecting wounded and dressing them as best we could in the field all night, and then, with any help from the regimental doctors if they could spare it, work away as hard as we could for the next forty-eight hours. Let's hope they'll all be Boers. I should like the Boers to get one good licking. We nailed nine of them to-day in a farm-house. The women folk said they had come in there for the night in order to give up their arms to our C.O. to-day! In Heilbron on Monday we captured thirteen wagons and had a fine bonfire, also a few Boers, so that there were two dozen or so trudging along with our column to-day, whereat my camera came into play.

At Heilbron we were received with acclamation. The supply department discovered three days' rations for the troops and two for the beasts, and we individually discovered many things more. I spent £4 or more in blankets, pipes, 5lbs. 'baccy, soap, handkerchiefs, castor oil and Cockle's pills, flour and egg-powder, candlesticks, bowls, and other things for hospital use, and weren't the patients just pleased! I told them they came from some kind ladies in England, but of course I scored most of the credit. I didn't say anything about it, by the way, when distributing the castor oil!

They of Heilbron received us with apparent warmth, but were very sick at hearing we intended to leave the place undefended. We have been worried by a small force of Boers all along lately, and the Heilbronners made sure they would be recaptured next day and would get beans for having sold us all their stores. However, we can't garrison every place we go through, and there are other troops close on our tracks. We had to leave thirty sick from one brigade in the Dutch Church there—wish I could have taken a photo of it—and about one hundred and fifty from our column altogether—*i.e.*, from about fifteen thousand men, representing three days' sickness, an average of one-third per cent. per diem—apart from temporary sickness. Of course, we only left rather serious or permanent cases there, for if the Boers came into the place afterwards they would make all the sick prisoners of war, and so deprive us of their services for the campaign.

Our column, you know, consists of ourselves (Gordons, Shrops, Cornwalls and Canadians, with two batteries R.A., etc.) under the dashing Gen. Smith-Dorrien, of whom we think no end; the 21st Brigade, under Gen. Bruce Hamilton (C.I.V., Derbys, Sussex and Camerons), and the 2nd and 7th M.I., I think, including Australians innumerable, the whole column under Gen. Ian Hamilton.

I forget when I last wrote. The last letter I have made a note of was from near Kroonstad, but I'm nearly certain I wrote from near Lindley last Friday.* We didn't go into Lindley, but let the 21st Brigade do that while we rested on Friday. You don't know how heavenly and Sunday-like a day of rest is to us. The only bother is the inevitable convoy of sick that must be arranged for. On Saturday we went about six miles to Paardeplacts, keeping half-way between the main railway and the Lindley-Heilbron road; on Sunday we did sixteen to Vaalbank, and joined the 21st Brigade again; on Monday, twelve to Paardekraal, and on Tuesday, eight into Heilbron. Yesterday we did thirteen more, and to-day fifteen. We were precious close to the Boers in Heilbron, De Wet having passed through it the same morning. We found the copy of a telegram from him to Steyn, saying he would not defend

* This letter has not yet been received.

the town, but the kopjes on the north-west of it. As a result, thirteen of his wagons were taken. N.B.—He had been previously blown to pieces by a shell a week ago, apart from numerous deceases on still more previous occasions.

Steyn and his Government—not in the guise of working men—held high revels in Heilbron on Saturday night, ending up with champagne—the only alcohol left in the town—at 2 a.m. They left no drinks for us—the cads. They went off in a great hurry on Sunday afternoon to Vrede, fifty miles to the east, presumably so as to get their guns and themselves across the Vaal and on to the rail again at Standerton. They may be preparing to receive us to-morrow at Vereeninging, in which they'll be disappointed. Perhaps they are shelling Buller by now.

I am now messing and living on a stretcher in a tent with Greich, the Captain R.A.M.C., only about two years my senior, who is responsible for both Bearer Company and field hospital. He is a capital fellow, and moreover we have a splendid cook, who makes us the most splendid steak and kidney pies you have ever tasted, and sat up till midnight yesterday baking bread for the men without an oven. All flourishing. F. E. F.

Some Notes on the Imperial Yeomanry Hospital.

Imperial Yeomanry Hospital,
Deelfontein,
June 18th, 1900.

We have had a terribly sad week since last I wrote to you owing to the death of two young officers, each of whom, though their ways laid far apart, had endeared himself to many members of our camp. Early in the week came the bare statement, and even yet we have heard no details at all, of the death in action of Lady Chesham's son. Only a few weeks ago he passed through here on his way to the front for the first and last time, and everybody who met him was won by his cheery good spirits and good heart. The day we heard the sad news our chaplain had a memorial service, for a gloom was cast over the whole of our camp. But it was only the forerunner of another event, the sadness of which came even more home to the staff and patients of this hospital, for in the death last Friday, the 15th of June, of Dr. Fitz-Hugh, everybody here felt that they had lost a friend whose value they had had the opportunity of realising. He was one of the juniors among our medical officers, but his practice here among the patients had cemented the high opinions which had been formed at Guy's by his teachers no less than by his contemporaries from his earliest student days, and which had been fortified by the high degrees he had taken at the London University. He was popular alike with his colleagues, with the nursing sisters, with the N.C.O.'s and orderlies, and with the patients. His career gave every promise of his attaining a very high place in his profession, but apart from his value to this hospital in his professional capacity, he had many characteristics which had endeared him to those who knew him. He was a thorough sportsman; a prominent member of our cricket eleven, though perhaps best of all at Association football, in both of which sports he used to play for Guy's when he was a student. He was a man with a keen sense of humour, and quite the most popular performer at the smoking concerts which do so much to keep up the spirits of our camp. One song of his in particular was so welcome that however much he tried to satisfy the audience with others, they would never let him leave the piano until he had given them their favourite. Poor old "Fitz," as we always called him, will not quickly be forgotten by his friends. There was an enormous congregation at his funeral service, the first part of which was held in the church. All ranks of the hospital were largely represented, and formed into a long procession to follow him to the cemetery about a quarter of a mile away. The coffin was carried by orderlies, and four of his fellow Guy's men acted as pall-bearers.

On the day that he died the entire staff was kept busy by the arrival of two trains full of sick and wounded, the first day on which we have ever experienced such a heavy "take-in." The first train load was the earliest out of Mafeking. Poor fellows, they were thin! But you will hardly need me to tell you this, nor that they were plucky! I was much struck by the coolness displayed by one of the officers. He was shot through the leg, and a few yards further on, through the chest. That brought him down, but the Boers put two more bullets into him at forty yards range while he was on the ground. He thought the best thing to do to save further damage was to sham dead. They came and looted his pockets and he found it very difficult to maintain the sham. Later on he was taken into the Boer laager as one of the wounded, and the first thing he did was to protest against having been looted before he was dead. This he did so eloquently that the Boer in command had his watch searched for and returned to him. Professor Chiene, of Edinburgh, came down with this train. The second train arrived from Winburg and Senekal, and out of its ninety-six occupants there were no fewer than fifty "stretcher" cases, *i.e.*, patients so gravely ill that they had to be carried from the train to their beds. Many of the wounded from the latter neighbourhood presented a feature which was entirely novel to our experience, in that they were burned more or less severely. It seems that our troops had to advance through veldt fires. A few of them were burned in running through, others only got their burns when they fell to the ground wounded, but from the accounts of the survivors I fear that there must have been others again still less fortunate, who, when they fell to the ground, were unable to move and were burnt to death. No. 3 Hospital Train, which brought the latter load, left again immediately for Mafeking, and Sloggett went up with it with the intention of bringing

down all the rest of the sick and wounded from that place. Still lying there is a cousin of mine, Major Mullins of the Imperial Light Horse, who, after being wounded through the shoulder at Elandslaagte early in the war, and then being locked up in Ladysmith throughout the siege and having enteric in Intombi camp, formed one of the relief force and had the bad luck to get wounded in the back just before they got into Mafeking. Professor Chiene, who saw him in Mafeking, tells me that both legs were completely paralysed at first, but that now there is so much improvement as to warrant the hope that he may regain the use of them both. I sincerely hope that Sloggett will find him and all the others still left in Mafeking, some fifty we were told, well enough to travel, in which case we shall have the pleasure of putting the splendid resources of this hospital at the service of all those who were laid up in Mafeking or wounded in its relief.

The blowing up of the railway north of Kroonstad has not really affected our material interests here at all, for most fortunately all three hospital trains (for a third one has just been improvised out of ordinary saloon carriages with a kitchen truck in the middle) were south of that part at the time, and therefore their regular running has not been interfered with.

Professor Chiene, I daresay you will remember, was originally coming out as senior surgeon to the 100-bed Scottish Hospital recently established at Norval's Pont, but the day before he left home he was appointed a consulting surgeon to the forces by the War Office in one of the vacancies created by the home-going of Sir William McCormac and Mr. Treeves. He stopped the whole day with us, and I took him all round the hospital. He made a most minute inspection of everything, and carried away for the benefit of the Scottish Hospital, to which he was going, a sample of any little device that struck him as novel. He was much fascinated, for instance, by the way buckets are improvised here out of empty oil cans. He and the two other doctors and the two sisters on the Mafeking train lunched and dined with us, and he left again late at night, having expressed himself extremely pleased with everything he saw. The operating theatre, the laundry, the disinfectant house and the latrines were the parts he admired most of all.

We have had to turn one of the smallest huts into a sick room for the sisters. They are so closely packed in the ordinary sisters' sleeping huts that it is extremely inconvenient there when one of them is ill. I am glad to say that there are no serious cases amongst them, but their work is very heavy now, and their sick room is in perpetual request for slight cases. Greenfield and Parker, the other two doctors who I told you had enteric, are both doing well. Three others of our medical staff have had to be admitted to the officers' ward during the past week, but we do not think that any of them have enteric. Exactly a quarter of the orderlies we brought with us are now sick in hospital. In spite of this attenuation of our staff we are still expanding our accommodation, and have now 800 beds, although nearly 100 of them are not occupied, fifty being reserved for our expected load from Mafeking, and thirty to forty we always keep vacant, as I have told you before, for chance arrivals.

Fitz-Hugh really did not suffer at all, nor had he any notion that he was dying. He went quite off his head about forty hours before he died. Just as he was getting light-headed, I sat with him for a long time. He said he felt "all right" and "very comfortable." His two nurses were neither from Guy's, but they were indefatigable in their attentions and devoted to him, and he expressed himself as most contented with them. In fact I don't believe he "wanted for" anything, nor suffered at all from beginning to end. He had no diarrhœa, and no grave symptoms until he went off his head. I expect others are writing from here to Guy's, but will you please undertake to see that his many friends are correctly informed through Guy's GAZETTE.—Yours always,

ALFRED D. FRIPP.

Abdominal Injuries.

(Read before the Physical Society by Mr. FRANK CROSS, and received the Society's second premium.)

MR. CHAIRMAN AND GENTLEMEN,—Before commencing the paper which I have the honour to read before you to-night, I should like to point out that, although the title has been announced as "Abdominal Injuries," I would prefer a modification to "Abdominal Injuries without External Wound," as it is that class of case only which I intend bringing to your notice. I should also like to explain my reason for choosing such an apparently uninteresting subject. At the time I was honoured with your invitation, my duties took me frequently to the front surgery of this hospital, where on many occasions I was forcibly struck by the great difficulty experienced in the diagnosis of Injuries to the Abdomen. Now, gentlemen, as you all know, this class of case is one of the most important with which the surgeon is called upon to deal, for upon his prompt and correct diagnosis and treatment frequently depends the life of the patient, and very often the reputation of the surgeon.

Introduction.—Injuries to the abdomen are accidents generally of a grave character, with the effects of which the surgeon has frequently and very often hopelessly to combat.

Like those of the skull, they derive their principal importance from the nature of the structures contained in the cavities. The integument and muscles forming the abdominal wall may be severely injured, yet results follow which are simply of local importance, but if the viscera or peritoneal lining are involved, the case immediately becomes one of considerable danger.

In the first place let us consider the extremely delicate structures with which we have to deal in this region: a serous membrane readily prone to inflammation

stomach and lengthy coils of intestines, readily lacerable solid viscera, such as liver, spleen, etc., the great vessels, and last, but not least, the sympathetic plexus of nerves.

The liver, spleen, and intestines are all liable to be torn, lacerated, cracked, or crushed by a blow, or transmitted pressure, and when such an accident takes place, a fatal result may generally be anticipated unless prompt measures are taken. Therefore, it is of the greatest importance that we should study with the utmost care the signs and symptoms of such injuries.

A blow, kick, or fall on the abdomen, the passage of a wheel over it, or a jamb between two opposing bodies, must never be judged of lightly, must always be regarded with suspicion. Many a trivial blow has resulted in sudden and unexpected death, or in subsequent fatal inflammatory mischief.

A typical instance is recorded by Mr. Bryant of ruptured intestine caused by a small stone thrown from afar.

Diagnosis.—In "Surgical Diagnosis" 1869, Le Gros Clark says, "I am unacquainted with any diagnostic sign by which we may judge whether shock following an abdominal injury exists primarily, apart from, or as expressive of actual breach of texture. Time alone can develop the true nature of the case, either by renewal of vigour, or by the development of fresh symptoms."

These words, gentlemen, express more or less my own opinion, formed after a careful review of some years of our surgical reports, and a necessarily short experience in the surgical wards of this hospital, and I feel sure that the only way to arrive at a diagnosis at all satisfactory is to consider each viscus separately and systematically, and arrive at our conclusions by a process of exclusion.

Let us first consider which viscus is most frequently ruptured.

Treves, in his "System of Surgery," gives the following order of frequency:—1. Liver. 2. Spleen. 3. Kidney. 4. Stomach. 5. Intestines. Out of seventeen recorded cases of fatal rupture of viscera, the liver was concerned in nine instances. Among rarer injuries may be mentioned tearing of gall-bladder, rupture of spermatic cord or of ureter, and laceration of the mesentery; rupture of the peritoneum alone is rare, but undoubted examples of this injury have been recorded. There appears to be no recorded instance of rupture of the pancreas.

Out of twenty-five autopsies performed upon subjects of abdominal injuries in this hospital from 1895–1898 inclusive, the following viscera were found ruptured:—

Spleen.—Twelve times.
Liver.—Eight times.
Kidney.—Eight times.
Alimentary Canal—Six times, made up as follows:—
a. Stomach twice.
b. Small intestine once.
c. Cæcum once.
d. Colon once.
e. Sigmoid once.
Pancreas.—Once.
Gall Bladder.—Once.
Peritoneum only.—Once.

I have found no cases of death from tearing of large blood-vessels, although it undoubtedly does occur, and Treves quotes "several instances of laceration of the vena cava," and he remarks that "the veins are much more frequently torn than the arteries."

Before going further I think it will be best to advert to a few of the more noticeable features that generally appear in severe abdominal lesions, and keep them in mind as a standard of symptoms.

(1). There is the Primary effect, or general constitutional disturbance.

(2). There is the Secondary effect, or peritonitis, into the symptoms, etc., of which time will not permit my entering.

1. The primary effect is often but of short duration. Directly after receiving the blow the patient may be able to stand up, but is soon seized with a kind of faintness, rapidly succeeded by chilliness ending in collapse. Soon a slight reaction ensues, and he complains of great pain at the seat of injury, probably radiating to every part of abdomen. His face is pale, anxious and distressed. He is bathed in a cold sweat, and extremities are cold. The pulse is weak and rapid. He may complain of great thirst. Vomiting probably takes place and it may contain blood. The abdomen becomes rigid, distended, and tympanitic, or flat and board like, and the breathing is almost entirely thoracic. Retention of urine is frequently present. These symptoms may be more or less modified by

a. The viscus ruptured.—For instance, should it be one of the solid viscera, such as liver, spleen, etc., there would also be evidence of internal hæmorrhage, such as blanched appearance of surface and mucous membranes.

b. Size of rupture.—The intestine may be completely torn across, or only have a rupture the size of a pin hole.

c. Condition of viscus.—If empty, or distended with air, food, fæces, or urine, at time of rupture.

d. If patient is carefully treated directly after the accident, is not allowed to walk, and not given fluid by mouth to stimulate him or to allay thirst, nature being thereby given a chance of sealing the ruptured spot, if small, by adhesion to some neighbouring viscera. In those cases where death is the immediate result, this is no doubt due to shock, and it is often found that the blow has fallen more or less directly over the region of the solar plexus, or that an extensive area of peritoneum has been involved.

I think it will not be out of place if we recall to mind the nerve supply of this part of the body. The skin over that part of the abdomen beneath which lie the chief viscera is supplied by the lower seven dorsal nerves. The same nerves supply the muscles of the belly, viz., the rectus, two obliques and transversalis. They also take an important part in the nerve-supply of the peritoneum and abdominal viscera, through the splanchnics and great abdominal plexuses. Thus, with lesion of the peritoneum or any viscus, the muscles of the belly wall contract and the skin becomes more or less hyperæsthetic

with a view to securing rest and protection to the injured parts.

In making our diagnosis we should not content ourselves with merely endeavouring to make out symptoms in the patient himself, but should always try to obtain from an eye witness every detail of the accident, especially as to the nature of the force and the position of the patient at the time of injury. Dirt marks, tears, etc., on patients' clothes will materially help us. Of course it is obvious that the greater the force employed, the greater in all probability will be the injury, but on the other hand, cases are quoted in which two wheels of a loaded vehicle were *known* to have passed over a boy's abdomen, doing no more harm than that caused by fright. From the records of the years 1895–98, I have collected no less than nineteen cases of patients being brought in with signs of severe abdominal lesions, where it has been definitely proved by witnesses, and corroborated by marks on clothes and bruises, that one or more wheels of vans, cabs, etc., have passed completely across the abdomen, and yet patient has been discharged apparently well in a few days.

The passage of a wheel over the abdomen is likely to produce a general bruising or laceration of parts, whilst a blow from a small instrument, such as the sharp end of a van pole, or a kick from a horse should always make us suspect the perforation of some hollow viscus; this will be eminently more likely to happen should the viscus be distended in any way at the time, and therefore careful enquiry should always be made as to the relation of time of the accident to that of the antecedent meal or act of micturition. Shock and collapse is always alarming, and often indicate extreme danger, yet as I shall be able to show you in some of the cases I have collected, when the collapse is extreme the injury often turns out to be one of a trivial nature, while in other cases where there is little or no collapse, the patient dies in a few hours.

As an example of extreme symptoms without any apparent lesion I will quote the following:—

Frederick L., æt. 6, was admitted under Mr. Howse, 1896, two wheels of a four-wheeled van having run over his abdomen. Patient vomited at time of accident. He was conscious but much collapsed. Pulse 120, weak; respiration 28, short and entirely thoracic; temperature 97·8°. Vomited again on admission. Abdominal wall rigid, very tender, and showed marks of bruising. Patient made an uninterrupted recovery and was discharged four days after admission.

1896. A man was admitted under Mr. Lucas, a cart having turned over and crushed his abdomen. On admission he was very collapsed but conscious. Temperature 97·6°: pulse 130, small, weak, and irregular; abdomen rigid: respiration thoracic. Was discharged after four days.

1896. A man was admitted under Mr. Lucas, having been struck violently in the epigastrium with the pole of a van. He was much collapsed and dazed. Abdominal wall very rigid, but not distended. Temperature 97·6°; pulse 160 and weak. Discharged well five days after admission.

These, gentleman, are a few of the many similar cases recorded in our surgical reports.

I will now quote cases where the symptoms have been slight, and yet the patient has sooner or later succumbed to fatal internal injuries.

1896. A man, æt. 67, was admitted under Mr. Davies-Colley, a cab wheel having passed over his abdomen. He walked up to the hospital, was somewhat pale, and had a lump in the right iliac region. He retched once or twice. Pulse 120; respiration 30; temperature 100·4°. He was put to bed and an ice bag applied to swelling in iliac region; he felt comfortable all that night and next day. The second night he vomited frequently. and died the day after. At the autopsy it was found that patient had a malignant growth of hepatic flexure of colon which had been adherent to inferior margin of liver. The colon was here ruptured for one and a half inches, being torn away from the liver, which had formed its upper wall.

1896. A man was admitted under Mr. Lucas, the wheel of a van having passed over his abdomen the day before admission. Feeling bad the next day, he walked up to the hospital, and died within twenty-four hours of admission. Autopsy showed a tear in sigmoid half an inch in length, and general peritonitis.

1897. A man was admitted under Mr. Howse, a cart wheel having gone over his abdomen. He had some pain in abdomen, but was not at all collapsed and had a good pulse. Next day he became bad and died in the evening. The autopsy showed much *perirenal* hæmorrhage, spleen ruptured, and liver ruptured in two places.

1897. Under Mr. Golding-Bird. Patient was a man who had fallen off a wall about twelve feet high, on to his abdomen. The report says, patient walked into the front surgery; he was drunk and refused to sit down, but walked about, being alternately jovial and pugnacious. He frequently expressed a desire to micturate, but was unable to do so. He was admitted, and went on well for four days, when he suddenly became worse. Abdominal section was performed, but he died on the fifth day. The autopsy revealed a ruptured bladder.

In 1881, Mr. Wm. Walker, of Doncaster Infirmary, reported a case in the *Lancet* of a man who was supposed to have been run over. He was drunk when admitted, and was admitted more on the strength of the history of accident, as he had no symptoms of any injury. He slept all night, and next morning said he felt quite well and wished to go out. He was permitted to get up and walk about the ward. He died suddenly thirty-six hours after admission, and post-mortem showed that jejunum was completely severed.

Here again, gentlemen, I have given you only a few of the many cases of a similar character which I have noted during my investigations in this subject. You will perhaps have noticed that in the last two cases the patients were under the influence of alcohol, and I have been particularly impressed with the fact that in nearly 50 per cent. of the fatal cases, where there have been

few or no symptoms, the patients have been in a similar condition at the time of injury; it therefore, I think, behoves us not to treat a history of abdominal injury to a drunken man too lightly, although there may be no signs or symptoms present.

Should the patient have a return of the collapse, or a series of returns, that is an indication of serious mischief, for it means either a secondary hæmorrhage or a giving way of some bruised tissue, probably permitting extravasation from some hollow viscus.

When collapse is very prolonged, presence of hæmorrhage may fairly safely be diagnosed.

Too much stress must not be laid on the fact of there not being any external signs, such as bruising or abrasion, for as you have already seen from the few cases I have quoted above, the gravest internal injuries may coexist without any external mark, and the surgeon must then depend somewhat on the evidence of eye-witnesses. We cannot rely to any great extent on the history given by the patient himself, as he is generally too much upset to know what really happened. If, therefore, there is local evidence enough to tally with the circumstantial evidence of witnesses, one would be quite justified in diagnosing internal mischief, even if the symptoms of shock and collapse did not at the time point to it.

Retention of urine.—As regards retention of urine in abdominal injuries, I have noted it as being present in sixteen cases out of seventy-five, all sixteen, I may add, being more or less severe as regards collapse, though the bladder and urethra have remained apparently uninjured.

Loss of consciousness.—When the patient first comes under your notice, you will nearly always find that there is no loss of consciousness, however severe the injury may be. In fact, out of eighty cases that I have investigated, it has only been present on three occasions, one of which was complicated by a fractured base.

Pain.—Pain as a symptom of diagnostic value is very confusing, since it depends much upon the personal equation of the patient. Some patients who are brought in here in the most acute agony go out again within a week perfectly well; whereas a patient will sometimes wish to go out, insisting that he is all right, and yet later on develope most serious symptoms.

As an example of the amount of pain a man can endure without collapsing, I will quote the following interesting case, although I shall hardly be keeping to the title of my paper, as it is not an abdominal injury without an external wound:—

In 1843 a man was admitted under Mr. Key, having stabbed himself in the abdomen with a knife. He came up to Guy's some hours after in a cab, into which he had got without any assistance, having previously walked twice up and down stairs from the room where he had slept. There was a wound at umbilicus one and a half inches long, and from this protruded a large confused bloody mass, consisting of the whole of the arch of the colon, torn away from the mesocolon, the omentum, and a considerable portion of the small intestine; the omentum was torn to shreds, the colon also torn in two, the ends hanging down on either side of the abdomen. The whole mass had a most offensive odour, was completely infiltrated with blood, and had evidently been exposed for several hours. He was very slightly collapsed. The protruding mass was washed and returned into the abdomen, except the two ends of the colon. His condition improved all that day and all the next, but in the evening of the second day he sank rapidly and died the same night.

Vomiting.—Persistent vomiting is always a serious sign. When you are told that the patient vomited at the time of the accident but has not vomited since, that need not be looked upon in so serious a light, for it is probably only the evacuation of the stomach's contents due to shock.

Out of the seventy-five cases I have collected, vomiting at time of accident occurred in thirty-one, the majority of them being not injuries of a crushing character, as from a cart wheel passing over abdomen, but taking the form of a sharp blow in the epigastric area, as from a van pole, kick from a horse, or punch with a boxing glove. The following case is a type of many I could quote well illustrating this fact.

A man was admitted under Mr. Golding-Bird in 1897, the pole of a van having jammed him against another van. There was some bruising about two inches above umbilicus. He vomited at the time of receiving the injury but did not do so after admission. He was discharged well six days after accident.

Mr. Bryant has said, "Should the vomiting start early after the accident, and persist, it generally indicates injury high up in the alimentary canal, especially if blood should be present. Should blood be present in the first vomit, injury to stomach should be suspected, should it appear in the vomit later, then the question of injury to intestine lower down, as in upper extremity of jejunum may be raised.

This, I think, you will agree, seems to be the proper view to take of this symptom, but I have been unable to substantiate it by autopsy in any of the cases I have investigated.

The following case, however, was reported in the *Lancet* in 1884. A man was struck in the abdomen by a fragment of broken grindstone. He was collapsed. Abdomen universally tender, no dulness in flanks. Soon after admission he began to vomit coffee-ground matter streaked with bright red blood. He died seven hours after accident, having vomited continually. At the autopsy the posterior wall of stomach was found to have a rupture one inch in extent, and on the anterior wall the peritoneal and mucous coats were torn for one inch, but the muscular coat was intact.

I have here a specimen which shows laceration and detachment of the mucous membrane of the stomach over an area of about two inches. It was from a boy aged 9, who had been run over. He vomited blood-stained fluid shortly after, and died next day. In addition

to this injury he had also laceration of the liver, extravasation of blood behind the pancreas, and a broken thigh.

These two cases bear out Mr. Bryant's remarks, and also point to the fact that a hollow viscus may be bruised or partly torn through, the injury being confined to one or two of its coats only. As this specimen shows, thus we may have laceration of the serous coat but not the mucous, or vice versâ, and many of these cases if treated properly may eventually do well.

The following case is one that might rightly be diagnosed as ruptured internal coat in some part of the alimentary tract, probably the large intestine, as there was no vomiting. Patient was admitted under Mr. Davies-Colley, 1895, for an injury caused by the handle of a truck striking his abdomen. He felt sick at the time but did not vomit, and resumed his work soon after. That night he had some pain in abdomen, and this recurred at intervals getting considerably worse, so that five days after accident he came up to Guy's. On admission, his abdomen was painful, rigid, and distended. Pulse 92, strong, temperature 99·4°, respiration 18, mostly thoracic. There was dulness below umbilicus on right side. On the seventh day after the accident his bowels were opened for the first time, the motions containing dark blood, and also some of a bright red colour. He went out recovered thirty days after receiving the injury.

(To be continued).

Davies-Colley Memorial Fund.

LIST OF FURTHER SUBSCRIPTIONS.

	£	s.	d.
Amount already acknowledged ...	133	4	6
Dr. P. H. Pye-Smith	10	10	0
C. H. Golding-Bird, Esq.	10	10	0
Dr. F. W. Pavy	10	10	0
Sir Samuel Wilks, Bart.	5	5	0
W. H. Jalland, Esq.	5	5	0
Dr. A. H. Spicer	5	5	0
G. W. Shipman, Esq.	3	3	0
R. Wynne Rouw, Esq.	3	3	0
Dr. Thos. Stevenson	2	2	0
W. H. Crosse, Esq.	2	2	0
C. A. Aitkin, Esq.	2	2	0
Dr. J. F. J. Sykes	2	2	0
G. A. Wright, Esq.	2	2	0
Montague F. Hopson, Esq.	2	2	0
Dr. R. S. Wainewright	2	2	0
Dr. John Fawcett	2	2	0
C. J. Ogle, Esq.	2	2	0
Dr. E. Clifford Beale	2	2	0
Dr. B. N. Dalton	2	2	0
R. J. Pye-Smith, Esq.	2	2	0
Charles Caldecott, Esq.	1	1	0
W. C. C. Park, Esq.	1	1	0
J. J. Cardin, Esq.	1	1	0
Dr. John Ince	1	1	0
Dr. W. Culver James	1	1	0
J. McD. McCarthy, Esq.	1	1	0
H. W. Pigeon, Esq.	1	1	0
C. J. W. Pinching, Esq.	1	1	0
J. T. J. Morrison, Esq.	1	1	0
Hugh Bennett, Esq.	1	1	0
Dr. Stephen Floyd	1	1	0
T. M. Nicholson, Esq.	1	1	0
J. C. Baines, Esq.	1	1	0
Dr. R. W. Mothersole	1	1	0
Dr. A. P. Beddard	1	1	0
St. Clair B. Shadwell, Esq.	1	1	0
R. Hilton Fagge, Esq.	1	1	0
Dr. T. Wilson Smith	1	1	0
Sir Joseph Ewart	1	1	0
Dr. J. W. Russell	1	1	0
H. Jones Roberts, Esq.	1	1	0
R. B. Stamford, Esq.	1	1	0
H. F. Bourne, Esq.	1	1	0
J. L. Wartski, Esq.	1	1	0
Owen Gwatkin, Esq.	1	1	0
G. E. Duncan, Esq., R.N.	1	1	0
Henry Blatherwick, Esq.	1	1	0
Lieut.-Col. C. White	1	1	0
B. Rix, Esq.	1	0	0
W. J. Henson, Esq.	0	10	6
Edgar Evans, Esq.	0	10	6
C. F. Wakefield, Esq.	0	10	6
O. B. Shelswell, Esq.	0	10	6
W. W. Leigh, Esq., J.P.	0	10	6
W. L. Bowen Davies, Esq.	0	10	6
Dr. A. M. Daldy	0	7	6
J. T. Knight, Esq.	0	5	0
T. Holmestead, Esq.	0	5	0
H. Hearnden, Esq.	0	5	0
J. Ponsonby, Esq.	0	5	0
H. Elliott Blake, Esq.	0	5	0

THOS. G. STEVENS,
Hon. Sec.

Reviews.

A Manual of Medicine. By W. H. Allchin, M.D., Senior Physician to the Westminster Hospital. Vol. I. (London: Macmillan & Co.) Price 7s. 6d. net.

The first volume of the "Manual of Medicine" fulfils our expectations, and if the remaining four volumes are in any way comparable to the one we have before us, Dr. Allchin may feel congratulated upon the result of his labours.

In this first volume we have articles by well-known physicians and specialists upon the various fevers, infections, and diseases due to atmospheric influences. Dr. Caiger has written the descriptions of diphtheria, scarlatina, rötheln, measles, and varicella, whilst Dr.

Cayley has given us an excellent account of typhoid fever.

The short article on "epidemic pneumonia" seems but an apology for the introduction of this subject among the fevers, although Professor Osler, in the last edition of his work on Medicine, unhesitatingly places this disease along with the infective fevers.

Mr. Cantlie has written eleven articles on various tropical diseases, including malaria, dysentry, plague and cholera, and Professor Sims Woodhead has important contributions on infections, sapræmia, septicæmia and pyæmia.

There is only one complaint we have to make, and that is in regard to the subject of treatment. As in many other text-books, this book gives an altogether inadequate description of this important branch of medicine. We find in the case of every disease a complete account of etiology, pathology and symptoms, but feel disappointed that the treatment should be disposed of in a few lines by all the contributors except Dr. Lees, Dr. Cayley and Mr. Cantlie.

The paper, printing and binding are all that can be desired, and there are twelve coloured figures as well as numerous temperature charts scattered throughout the book.

Materia Medica. (Lewis, Gower Street.) 1s. net.

Assuming that Materia Medica is a subject for cramming, and that therefore a pocket edition is of much value, it follows that publishers should vie with each other in endeavouring to produce the smallest sized book. Messrs. Lewis, Gower Street, hold the record in their "Materia Medica," 1s. net, which is 4 in. by 3½ in. by ⅓ in., and weighs about ʒii., bound in cloth.

Zoology, Pt. 1 (Catechism Series). (Edinburgh: E. & S. Livingstone). 1s. net.

This little book should prove useful to students learning systematic Zoology from the examination point of view. It is written in the form of question and answer, and for the most part the answers are accurate, short, and to the point. We do not recommend this form of teaching as a rule, but where the student has already mastered his principles, the book may prove of use to show how to frame answers to questions.

Also received:—Stethoscope, Clinical Journal (3), Hospital (3), Broadway, London Hospital Gazette, Le Moi's Medico-Chirurgical, Therapist, Medical Examiner, Climate, St. Bartholomew's Hospital Journal.

NOTICE TO CORRESPONDENTS.

Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Guy's Hospital Dental Society.

THE sixth annual meeting of the society was held on May 29th.

Mr. Prall (hon. sec.), in submitting his annual report, suggested two points which the meeting placed in the hands of the committee for consideration, viz. (1) The hour of the meetings, and (2) Whether the present insurance was sufficient to cover the increase of instruments that has occurred. Mr. Prall remarked that financially the society was a great success, that the papers read at the meetings had perhaps hardly been up to previous standards, and concluded his report by acknowledging with sincere thanks the kind and liberal assistance which had been rendered him by the President, Vice-Presidents, Curator of the Museum, Committee, and many others, during his term of office.

The election of new officers resulted as follows:—President, J. Lewin Payne, M.R.C.S., L.R.C.P., L.D.S. Vice-Presidents, A. E. Baker, M.R.C.S., L.R.C.P., L.D.S.; F. W. Cock, M.D., M.S.; C. H. Fagge, M.S., F.R.C.S.; E. B. Dowsett, M.R.C S., L.R.C.P., L.D.S. Hon. Sec. and Treasurer, S. C. Bowle. Committee, E. J. Gaffney, W. E. Low, C. A. W. Buckell, L. Myer, H. C. Winckworth.

In view of the usefulness and popularity of the Clinical evening, it was agreed that two extra meetings for this purpose should be held during the summer months. The decision as regards the Society's Prize was withheld pending an agreement among the vice-presidents.

The President (Mr. Baker), after delivering his valedictory address, presented the society with a valuable gift of extremely interesting antiquated dental instruments.

Mr. Lewin Payne terminated the proceedings with a vote of thanks to Mr. Baker for his services as president, remarking on the excellent way in which the presidential traditions had been maintained.

A vote of thanks was also accorded to Mr. Prall, whose duties, admirably fulfilled, have contributed in a great degree to the success of the society.

The meeting desired the secretary to convey to Mrs. Lidiard its sincerest sympathy in her sad and sudden bereavement.

S. C. BOWLE,
Hon. Sec. and Treasurer.

RECENT ADDITIONS TO THE DENTAL MUSEUM.

1. The head of a pike. Mr. J. H. Badcock.
2. The jaws of the Anarrhicus Lupus. Mr. J. H. Badcock.
3. A specimen illustrating a badly-crowned root and its effects. Mr. H. J. Webb.
4. An upper molar exostosed and absorbed. Mr. H. J. Webb.
5. A lower molar with a distinct fissure and a pit in the roots filled in by soft tissues in the natural state. Mr. Bartlett.

6. Specimens of old bone dentures. Mr. A. M. Gabriel.
7. Two lower incisor teeth with large deposits of salivary calculus.
8. Model of a Hayward's splint. Mr. J. Lewin Payne.
9. Model of a Kingsley's velum. *Ibid.*
10. Model of a Sercombe's velum. *Ibid.*

J. LEWIN PAYNE, Curator.

Sport.

Cricket.

REIGATE PRIORY v. GUY'S.

The match was played at Honour Oak on Saturday, June 30th, and resulted in an easy win for the Hospital. The wicket was very soft in the morning, which makes all the more creditable the fact that Barber and Langdale put on 167 runs for the third wicket. We batted first. Poyser took 4 wickets for 10 runs. Scores:

REIGATE PRIORY.

J. W. Neale, b M. Wetherell	14
G. K. Oliver, b M. Wetherell	3
W. H. Birkin, c & b Poyser	20
—. Montgomery, b M. Wetherell	12
R. W. Neale, c Barber, b Poyser	7
F. Nightingale, st Smith, b Poyser	2
W. H. Gullier, b Trubshaw	0
F. C. Morrison, run out	6
J. P. Goodall, c Cowper, b Poyser	5
A. P. Douglas, c Langdale, b Trubshaw	3
A. H. Dunning, not out	0
Extras	17
Total	89

GUY'S.

H. Barber, c Goodall, b Birkin	95
F. Morres, b Morrison	2
R. Poyser, c Nightingale, b Montgomery	1
H. M. Langdale, b Birkin	77
K. V. Trubshaw, b Birkin	38
E. A. Collins, b Birkin	0
S. C. Bowle, c Oliver, b Montgomery	24
M. C. Wetherell, not out	0
Extras	19
Total (7 wkts.)	256

E. S. Graham Smith, J. T. Hicks and C. M. Cowper did not bat.

GUY'S 2ND XI. v. ST. BART.'S 2ND XI.

(WON BY 67 RUNS).

Played at Winchmore Hill on Saturday, July 7th. Score:—

GUY'S.

K. V. Trubshaw, b Turner	12
M. C. Wetherell, b Turner	37
R. C. Poyser, b Turner	18
S. C. Bowle, b Corbyn	0
A. M. Tollhurst, not out	18
A. H. Turner, b Corbyn	0
F. C. Robinson, b Turner	16
J. T. Hicks, c Corbyn, b Turner	7
E. W. Strange, c & b Corbyn	7
Extras	9
Total	124

ST. BART.'S.

J. Lloyd, b Wetherell	7
L. Gray, b Bowle	1
C. Elliott, b. Wetherell	16
L. B. Rawlings, b Bowle	1
C. H. Turner, b Whetherell	1
L. Corbyn, b Wetherell	13
L. Chambers, b Bowle	6
A. M. Wilson, b Wetherell	4
R. D. Butcher, b Wetherell	0
P. Griffin, c Strange, b Bowle	0
H. Pritchard, not out	0
Extras	8
Total	57

Guy's Hospital Lawn Tennis Club.

GUY'S v. HAROLD.

The return match v. Harold was played at Gipsy Hill on Saturday, July 14th. Except that there was a slight wind, and that the courts had suffered a little from constant wear, the conditions were the best possible for tennis.

Even the hospital representatives were a little keen about the match, as our matches v. Harold stood five all up to date, and in addition there was a strong Guy's element among the spectators.

For the fourth match in succession Guy's were successful, winning easily by 7 matches to 2—105 games to 69. Score:—

H. K. Lacey and E. N. Jupp beat D. Colclough and L. Green, 6–3, 6–4; beat A. Eccles and J. E. L. Bates. 6–4, 6–3; beat G. Bright and G. Gibbs, 6–3, 3–6, 6–1. H. Bacon and B. H. Wedd lost to A. Eccless and J. E. L. Bates, 4–6, 2–6; beat G. Bright and G. Gibbs, 6–1, 6–3; beat D. Colclough and L. Green, 6–3, 6–4. H. N. Winckworth and G. T. Willan beat G. Bright and G. Gibbs, 4–6, 6–2, 6–3; beat D. Colclough and L. Green, 6–2, 6–1; lost to A. Eccless and J. E. L. Bates, 6–8, 2–6.

GUY'S v. LEIGHAM.

Played at Streatham on Saturday, July 7th, and resulted in a win for Guy's by 5 matches to 4, but on adding up the number of sets and games played, it will

be found that our opponents won one more set and one more game than we did.

Jupp, Wedd and Bacon were the only representatives of the 1st VI., Lacey, Wacher and Cooke being unable to play.

Holmes, who played with Bacon, was playing a good game, he being in his best form.

	Sets.	Games.
Leigham	11	104
Guy's	10	103

Score:—

E. N. Jupp and B. H. Wedd lost to Smith and Shattock, 1–6, 1–6; won v. Colley and Bush, 6–4, 6–4; won v. Pascoe and Stedman, 6–1, 6–3 E. T. Holmes and H. Bacon lost to Smith and Shattock, 3–6, 5–7; won v. Colley and Bush, 6–2, 3–6, 6–2; won v. Pascoe and Stedman, 7–9, 6–3, 6–2. C. Winckworth and J. Steele-Perkins lost to Smith and Shattock, 2–6, 4–6; lost to Colley and Bush, 4–6, 6–8; won v. Pascoe and Stedman, 4–6, 9–7, 6–4.

GUY'S v. WANSTED.

Resulted in an unexpected win for the Hospital by 6 matches to 2, one unfinished.

After the match the team enjoyed the hospitality of Dr. Hickman.

United Hospitals' Rifle Association.

U.H.R.A. v. CAMBRIDGE UNIVERSITY.

The above match was shot at Cambridge on June 9th, and resulted in a win for the University by 5 points. Scores:—

C.U.R.V. 637 points.

U.H.R.A.	200	500	600	Total
C. de Z. Marshall (St. Thomas's) (Capt.)	32	31	29	92
A. C. Brown (St. Bartholomew's)	29	29	31	86
C. M. Roberts (St. Thomas's) ...	25	30	30	85
R. J. Morris (St. Bartholomew's)	22	24	31	77
N. Carpmael (St. Thomas's).....	25	22	29	76
S. Hodgson (Guy's).....	26	28	21	75
O. B. Travers (Guy's)	25	23	26	74
J. Armitage	25	21	21	67
	206	208	218	632

U.H.R.A. v. H.A.C.

This match was shot at Ilford on June 26th. The Hospitals lost by 22 points. Scores:—

H.A.C. 562 points.

U.H.R.A.	200	500	600	Total
C. W. Wirgman (University) ...	31	31	29	91
C. de Z. Marshall (St. Thomas's) (Capt.)	31	26	32	89
C. Hodgson (Guy's).....	25	30	25	80
A. de Morgan (St. Mary's).....	24	23	27	74
G. F. Robinson (Guy's)	22	22	29	73
S. Hodgson (Guy's).....	22	29	19	70
C. M. Roberts (St. Thomas's) ...	21	28	14	63
	176	189	175	540

Appointments.

CIVIL.

Cresswell, F. P. S., B.S., B.Sc. Lond., F.R.C.S. Eng., has been appointed Assistant Ophthalmic Surgeon to the Cardiff Infirmary.

Hora, J., M.B., B.S. Lond., L.R.C.P., M.R.C.S., has been appointed Resident Medical Officer at the Infirmary of the King's Norton Union.

Leigh. William Watkin, L.R.C.P., L.M. Edin., M.R.C.S., L.S.A., has been re-appointed Medical Officer for the Llanvabon District by the Pontypridd Board of Guardians.

Morice, C. G. F., M.D. Brux., F.R.C.S. Edin., has been appointed Sanitary Commissioner for Westland and Buller, New Zealand.

Nathan, M.P., L.D.S., F.R.C.S. Eng., has been appointed Honorary Dentist to the Jews' Deaf and Dumb Home, Wandsworth.

Pedley, G. Aston, L.S.A., L.R.C.P. Lond., M.R.C.S., L.D.S. Eng., has been appointed Dental Surgeon to the Tonbridge Grammar School.

Sharp, H. C., M.B., B.C. Camb., has been appointed Medical Officer of Health for the City of Truro, *vice* E. Sharp, resigned.

Wright, G. A., F.R.C.S. Eng., has been appointed Honorary Surgeon to the Royal Infirmary, Manchester, in succession to Thomas Jones, deceased.

NAVAL AND MILITARY.

Staff-Surgeon C. M. Beadnell has been appointed to the *Immortalité*, Surgeon Gerald B. Brown, M.B., to the *Britomart*, and Surgeon J. W. Bird to the *Bramble*. Staff-Surgeon E. P. Mourilyan, of the South African Naval Brigade, has been invalided home.

Wheelton Hind, M.D., has been appointed Surgeon-Lieutenant in the 1st Shropshire and Staffordshire Volunteer Artillery.

At Windsor Castle, on July 7th, the following Companions of the Order of the Bath were introduced into the presence of the Sovereign, and Her Majesty the Queen was graciously pleased to affix to their respective left breasts the Decoration of the Military Division of the Third Class of the Order:—Colonel William Egerton Saunders, Royal Army Medical Corps, Surgeon-General Henry Skey Muir, Deputy Director-General, Army Medical Service, and Surgeon-Lieutenant-Colonel Benjamim Bloomfield Connolly, A.M.S.— *British Medical Journal*, 14th July.

Births.

HARDING.—On June 22nd, at Whittlsea, Cambs., the wife of C. H. Harding, L.R.C.P. Lond., M.R.C.S., of a son.

WALKER.—On June 26th, at Odos Solonos, Athens, the wife of Alfred W. Walker, L.D.S., M.R.C.S. Eng., of a daughter.

Ed.—S. H.

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Calendar of Coming Events.

August, 1900.

Sat. 11.—Messrs. Golding-Bird and Dunn's take-in; Drs., J. Evans and W. S. Davies; Cl., T. E. Holmes.

Library closed until September 1st, inclusive.

Thur. 16.—Messrs. Jacobson and Fripp's take-in; Drs., D. H. Trail and A. C. H. Gray; Cl., T. J. Wright.

Sat. 18.—Hos.-Scho. C. C., Crayford Y.M.F.S., away.

Thur. 23.—Messrs. Howse and Symond's take-in; Drs., J. E. Collins and F. D. S. Jackson; Cl., J. S. Steele Perkins.

Sat. 25.—Hos-Scho. C.C., Wandsworth Prison, home.

Guy's Hospital Gazette,

AUGUST 11, 1900.

The Treatment of Diseases of the Heart.

CLINICAL LECTURE BY DR. HALE WHITE.

May 30th, 1900.

Gentlemen,—You will remember that last time I was telling you something about a case of pericarditis, and I told you that patients having an adherent pericardium frequently suffered in the same way as those afflicted with valvular disease. We have so often in the wards to discuss the treatment of cases of heart disease, because they are so common, that I think it worth while to go over the subject to-day apart from any individual patient. For systematic teaching purposes I think we better, first of all, take the case of a patient who is so seriously ill from his heart disease, that he has to come into the hospital. You can easily picture to yourself the common features of such a case. The sufferer is very short of breath, usually his feet are swollen, he is rather livid, and there is a mitral regurgitant murmur. You all know this variety of cardiac disease, and now let us consider what we have to think of in treating such a patient.

I will take the subject under headings in order to make it systematic and therefore easy for you to remember. In thinking of the treatment of such a patient, the first thing we want to consider, because very important, is the *posture* in which you should put him. Think for a moment, and you will remember that one thing which is likely to trouble the patient very much, owing to the backward regurgitation, is œdema, and especially pulmonary œdema. It is obvious that if the patient lies on his back the pulmonary œdema will be likely to become severe; but if, on the other hand, he sits up the fluid may gravitate to the lower part of the body, and therefore there may be less pulmonary œdema. So that from the point of view of perhaps the most important complication, namely, œdema of the lungs, it is obviously better that the patient should sit up when he has heart disease.

Then there is a second reason why he should assume that posture. You know that most of these patients have a large liver, often reaching down to the umbilicus, and if the patient lies down the heavy liver falls against the diaghragm, and so impedes the action of the already diseased heart. That is the second reason why these patients should sit up, namely, that then the heavy liver drops away from the heart and therefore does not interfere with its action.

Then, too, there is the awful dyspnœa from which these patients suffer. It is often much benefited by the erect posture, quite apart from pulmonary œdema or a big liver. From time to time we get in the hospital some of the saddest cases, I think, we see, namely, people either with heart disease or with aneurysm who have to spend the night in a chair by the fire because they literally cannot lie down. Even the prospect of bed is so frightful to them that I have known them spend weeks in a chair by the fire. With these patients there may be no pulmonary œdema, and no big liver, but for some reason which we cannot explain they do not become dangerously breathless in the erect posture, but they do in the recumbent.

You will now, I hope, remember that generally speaking it is desirable for the patients suffering from such heart disease as we are discussing to be sitting up in bed rather than lying down.

The importance of posture is occasionally illustrated in a sufferer from heart disease if he happens to sleep with his arm hanging over the side of the bed. The next morning the whole arm may be œdematous. There is a man in Clinical illustrating this at the present time; if he lies a little on his side the skin on that side becomes œdematous more than on the other. In such persons posture is evidently very important, for you can see for yourself that a little leaning to one side may produce quite a local œdema of the skin. It is very desirable to provide patients with heart disease, who have œdema, with a sort of couch which is really a series of inclined planes. There is usually a movable inclined plane at the head, so that the patient can sit up, and a movable inclined plane lower down, so that you can elevate the feet to any angle you like. Some bed of that sort is the best bed for these unfortunate patients with heart disease.

Now, the next heading under which we will consider this question of treatment is that of *rest*. To the poor patient who is as ill as we have sketched, rest is absolutely essential; it must be absolute rest in bed, and it must be, if possible, carried to the extent of letting him always use the bed-pan and urinal rather than getting up to pass fæces or urine. These patients may improve so slowly that the mere exertion of getting up to walk to the water-closet may undo the good derived from two or three days' rest in bed. Try and train the sufferers, then, if they are as bad as we have painted, to rest absolutely. And they must have not solely physical rest, but also mental rest. You know that if you have an argument with a person, disagree with him and get excited and worried, your pulse rises several beats. Therefore it is cruel to go and tell a man with very serious heart disease anything that will worry him, or anything that will be likely to irritate him. He must have absolute physical and mental rest as far as he possibly can. Avoid all occasions of excitement and worry. It often happens that excitement is caused by visitors, who do the patient much more harm than good.

Another point which doctors are inclined to forget—and I have known serious accidents occur from forgetting it—is, that the opening of the *bowels* is a severe muscular effort, and you must never let a patient strain during that time. You must tell him on no account to strain if he feels he cannot get the bowels opened easily. Rather give him a purgative to gently move the bowels than that he should strain in the act of defæcation. Just think of the extra strain put upon the already dilated heart by the fixing of the chest that is necessary for the powerful action of the abdominal muscles.

The next thing you have to consider in a patient like this is, What *diet* shall I give him? If any of you have been at a post-mortem examination on a case of heart disease, you must in many instances have been struck with the state of the stomach; you may have seen the stomach livid, the veins in it quite large and obvious, and the whole of the stomach coated with a thick mucus which it really requires some pressure of water to wash off. And then you turn to the liver and you see it nutmegged and enlarged, and to the pancreas and you see that indurated, and the intestine itself is possibly congested too. You have only to look at such organs to see how little hope there is that their owner who is very ill with heart disease can digest even moderate quantities of ordinary food. Large amounts of food will be quite useless to him, and if they are useless to him they can only do him harm, because they distend the abdomen and make the difficulties of the circulation greater than ever. So remember this and give the patient small feeds, and feed at frequent intervals. Give him, say, two ounces of milk every hour, or a small teacupful of Benger's food, and the milk alternately every two hours; or stir some somatose into the milk. Anything in the way of light, simple diet will suit. You must not give patients of this description meals such as ordinary people have. You will have often to fight with the friends. They will say, "You are starving the patient!" but you will point out to them that it is no good whatever giving him food which he cannot digest. It is better, then, as I have said, to begin with small feeds, such as I have suggested to you, at regular intervals, and then, by all means, as the patient gets better feed him up, but you will not do this until you have got his digestive apparatus into such a state that he can digest and absorb his proper amount of food; till then excess of food is worse than thrown away.

We have pictured our patient as œdematous. Obviously therefore you will restrict the fluid given to drink. If he complains of thirst encourage him to bear with it, give him sips of warm water, but do not on any account allow him to drink *ad libitum*. The skin and kidneys have already got more than they can do to get rid of the œdematous fluid.

Then, in most cases, I think, do not prescribe any alcohol, but there is no reason why you

should not give it if you think it will aid his digestion. And sometimes it acts as a cardiac stimulant. But you will be guided by the individual cases.

The next point, namely, *vomiting*, we have often talked about in the wards. You have frequently heard me say that I know no symptom of heart disease which I would sooner were absent than vomiting. I hate to see it appear, because very often it is the first sign that the patient will rapidly go down the hill. If you think for a moment you will see that the patient may vomit for two or three reasons. He may vomit from the chronic, congested state of the stomach that I have already described to you. He may vomit reflexly because of the state of the heart. And, most important of all, you may be making him vomit by the drugs that you have selected to give him, and when vomiting begins you must stop immediately any drug that may be the cause of the sickness. You know that, unfortunately, the drugs which are usually given in cases of heart disease, such as digitalis, stropthanthus, and others of the digitalis group are drugs which may produce vomiting; they are gastric irritants, so that if any one of them is being taken and the patient is sick, stop the drug at once. That is by far the most important thing in the treatment of the vomiting. If, after you have stopped the drug, the vomiting still continues, there are several drugs that you can give. A good prescription is:—

℞ Bismuthi Carbonatis gr.80
Sodii Bicarbonatis gr.80
Liquoris Morphinæ Tartratis ... ♏80
Pulveris Tragacanthæ ... ... q.s.
Aquam ad ʒ8
Fiat Mistura. Take ʒi every four hours.

The reason I have chosen the carbonate and not the subnitrate of bismuth, is that the subnitrate is likely to irritate the stomach because of its nitric acid, and also the nitric acid will decompose the bicarbonate of soda and the resulting carbonic acid gas will blow the cork out of the bottle. Then I have taken the tartrate of morphine because it keeps better than the sulphate, the acetate or the hydrochloride. The object of the tragacanth is to suspend the bismuth. If at the end of one or two days the cessation of the digitalis and the administration of this mixture have not stopped the vomiting, try something like this:—

℞ Sodii Bicarbonatis gr.80
Acidi Hydrocyanici Diluti ... ♏30
Aquam ad ʒ4
Fiat Mistura.

℞ Acidi Citrici gr.70
Aquam ad ʒ4
Fiat Mistura.

Then mix half an ounce of each of these and give the mixture to the patient while it is effervescing. If none of these suit, tell the patient to sip a little hot water, or a little hot brandy and water. That may help to stop the vomiting. If the vomiting is very bad indeed, and the patient will let you, you may do good by washing out the stomach. But obviously, in a patient with heart disease, that requires some care, and you must be skilful in passing the tube. It is not worth doing unless the patient will submit quietly to have it done. When you wash out the stomach there is no need to use any particular solution. You can use boiled water at blood temperature.

Well, then, supposing the patient is still sick after all this treatment, as unfortunately they very often are, give him nothing whatever by the mouth, and feed him per rectum. The best way to feed the patient per rectum is, in most people, to give alternately, every four hours, a nutrient suppository and a nutrient enema. This latter generally contains the yoke of an egg with four ounces of peptonised milk. Never make your nutrient enemata large in bulk; the smaller the better. Choose a nutrient suppository which is really of use as a food; those, the basis of which is proteid, are excellent.

If, as may unfortunately happen, the patient gets no better, his condition generally becomes desperate. Very often, I am sorry to say, he dies from the vomiting. Sometimes when digitalis given by the mouth causes sickness, it will not do so if you give infusion of digitalis by the rectum, two drachms is about equal to one and a half drachms by the mouth. If the vomiting causes great collapse, then you can give strychnine, three minims of the 1 per cent. liquor, subcutaneously.

The next symptom that frequently baffles us is *flatulence*. That again is a most hateful symptom to deal with in cases of heart disease. If it is only slight it will often subside, provided you do nothing more than rest the stomach for twenty-four hours, and see that the bowels are properly opened. Also a hot flannel over the abdomen will often relieve the flatulence considerably. But frequently it is sufficiently troublesome to prevent any of these methods from succeeding. Then you turn your attention to the use of carminatives, but these are unsatisfactory, because, although so numerous, so few are really efficacious. I will just give

you one or two prescriptions that I have found to be more useful than others in such conditions. For instance, this is a good carminative mixture:—

℞ Tincturæ Sumbul... ... ... ℥1½
Tincturæ Carminativæ ... ... ʒi
Tincturæ Nucis Vomicæ ʒ1½
Syrupi Aromatici ... ... ℥ij
Aquam ad ... ... ℥6

Fiat Mistura. Take half an ounce every four hours.

The carminative tincture is a strong carminative containing cardamoms, ginger, cinnamon, carraway and cloves. If this mixture does not succeed you can try the following:—

℞ Spiritus Armoraciæ Compositi ... ʒi
Tincturæ Lavandulæ Compostæ... ℥½
Tincturæ Nucis Vomicæ ... ... ʒi
Aquam Cinnamomi ad ... ... ℥6

Fiat Mistura. Take an ounce every four hours.

You will remember that compound tincture of lavender contains oil of lavender, oil of rosemary, cinnamon and nutmeg, all of which are carminatives. Another way in which you may help these patients is by giving them some aromatic oils with a lump of sugar. Oil of peppermint is good if the patients do not object to the smell. Sandalwood oil is sometimes useful. A few drops of essence of ginger added to a very little water, may succeed, and some persons find a glass of liqueur brandy better than volatile oils.

I am sorry to say that, in spite of all these carminatives, very often you might just as well pour the medicine down the sink for all the good that it does for flatulence. And then you should try turpentine enemata, because turpentine may be an excellent carminative. The proportion is one ounce of the oil of turpentine to fifteen ounces of mucilage of starch. Throw that high up the rectum, and put some warm flannels on the abdomen, and you will sometimes get rid of the flatulence in that way. Do not think that flatulence in heart disease is a light matter, it is a very serious symptom. There is nothing, of course, that distends more than gas, weight for weight. Just think of the already dilated, weak heart, and you will easily understand how it will be hampered if a quantity of gas distends the abdomen and pushes up the diaphragm. This must obviously do the patient much harm, so that flatulence is a matter to be taken seriously in hand. Very often a tube is passed high up the rectum into the sigmoid flexure in the hope of drawing off gas, but I am sorry to say that generally it fails to do so, and it is not surprising, because the gas is very likely held up by some fold of the mucous membrane of the intestine.

The next point I have jotted down here as a matter to attend to is, whether the patient is *constipated*. That you must never forget. Now consider for a moment what kind of purgative the patient will require. In the first place, it is clear that if constipated he needs a purgative, for the straining, flatulence, distension and abdominal disturbance associated with constipation are obviously bad for a diseased heart. If the patient is very œdematous you will wish to draw off as much water as possible; therefore, you select a watery purgative, and there is no better than thirty or forty grains of compound jalap powder. If the patient is very œdematous, administer the jalap so that the bowels are opened at least once or even twice a day.

Supposing it is not œdema that troubles the patient so much as the fact that the liver is enlarged—often the liver may be down to the umbilicus, tender, painful, and perhaps the patient is a little jaundiced. There is nothing succeeds in these cases like a dose of calomel, usually about three grains. I think the powder is preferable to a pill, because there is just a chance that a pill may not easily dissolve, considering the state of the gastro-intestinal mucous membrane. And at the same time that you get the bowels opened with the calomel you relieve the pain in the abdomen at the situation of the enlarged liver. You must often have seen, in the wards, how wonderfully better pain and tenderness over the liver are, in cases of big nutmeg liver, when by calomel you open the bowels. Very often the relief of a large nutmeg liver is much helped by the application over the liver of three or four leeches.

The next thing you have to think of is, whether the patient can *sleep* properly. That is most important. You know it is a physiological fact that the pulse falls during sleep. Just think what a large amount of work less the heart has to do if, every minute for eight hours, that pulse drops, say, one-seventh of its beats which it may very well do. It is clearly a good thing for the patient to sleep.

Now the most important ways of getting him to sleep are, first, to see that he is in a comfortable posture. There is all the difference in the world between a good and a bad nurse in this matter. A good nurse makes the patient just comfortable and puts the pillows in such a way as tempts the poor man to sleep; while a bad nurse leaves him in such a position that

sleep is almost impossible. Then you will never get him to sleep if he is troubled with sickness, or flatulence, or if he is much constipated. You must try to get the gastero-intestinal tract right before you can get him to sleep. Then again, you will find that he will sleep better if he has plenty of fresh air. It is far better to have a fire and an open window, than no fire and a closed window. If you have done all this, and yet he does not sleep, what had you better do? What are the drugs that help sleep? For cardiac wakefulness probably chloralamide is the best. When this drug was first brought before the profession, some ten years ago, I administered it systematically to the patients in my ward—many of them being heart cases—and the results were published. They showed that in no way did it harm the heart or produce any dangerous symptom, and that it seemed peculiarly suited for heart cases. And ten years' experience has confirmed that result, and chloralamide is now used very often. It is insoluble in water, and difficult to manage in a mixture. The best way to give it is to put twenty or thirty grains in half a sherry glassful of brandy or whisky, whichever the patient prefers, and stir it up until dissolved, then add as much cold water as the patient likes, and let him drink it. You will often find that the patient or nurse will tell you that chloralamide will not dissolve in brandy or whisky. That is because it has not been stirred enough. It may take five minutes' stirring to dissolve, but it will dissolve if you take trouble about it. The advantage of giving it in that way is, that it is probably difficult of solution in the stomach, and therefore it should not be given in cachets. When the drug was first introduced and given undissolved sometimes the patients did not sleep all night, but slept all next day, probably because the drug had been dissolved so slowly in the body.

If chloralamide does not succeed try trional, it is best given in a cachet; fifteen grains is a very useful dose. Some patients find twenty grains of sulphonal given in the same way suits them. Let me warn you to avoid compressed tabloids, (for these drugs are frequently sold in this form) because very often compressed tabloids are not dissolved at all in the body. I have recovered numbers of compressed tabloids from the motions of patients who have been taking them. Obviously when this is the case they are virtually useless. It does not matter at all if a valetudinarian should pass these things undigested—probably with him it is better so—but when the patient suffers from heart disease it is a very serious matter indeed for the poor fellow not to be able to absorb the drug given to him.

Supposing there is great anxiety, oppression and pain, especially if the pain is permanent, then you must give morphiæ; a sixth of a grain subcutaneously is best. If there is much distress or anxiety, sometimes a little belladonna added to the medicine the patient may happen to be taking, or a belladonna plaster placed over the heart, will do something to comfort him.

The next thing we will discuss is the treatment of *œdema*. Now let us suppose, first of all, that it is very severe; there is great œdema of the legs, œdema of the abdominal wall, and fluid in the peritoneal cavity. Undoubtedly I think the best thing, when it is so severe as that, is to puncture the legs. You can do it either with a triangular needle or with Southey's tubes. Personally I think I prefer the needle, because tubes may get blocked. Now if I had been lecturing to you some years ago I should not have recommended in these cases that you should puncture, or I might have said that you should resort to it only in very extreme cases. The reason for the difference between the times is this. Some years ago people had not been taught, as a matter of routine, to be scrupulously clean, or, as we call it, aseptic, and there is no tissue that forms such a happy breeding-ground for all sorts of micro-organisms as staphylococci and streptococci, as œdematous tissue. Therefore, unless you are sure that the part can be kept quite clean, avoid puncturing if you can, for you are likely to induce inflammation, erysipelas or gangrene. I have seen a man suffering from heart disease with a dirty sore on his œdematous leg, and the sore spread so rapidly that he had to lose his leg, which was amputated above the knee. Again, patients have been killed from puncturing their legs. I heard only the other day of an old man whose œdema was due to Bright's disease, and within a week after his legs had been punctured that man was dead with all the symptoms of pyæmia. Œdematous tissues are very liable to that sort of trouble.

Therefore you must boil the needle and clean the skin, and do this very thoroughly. And remember that hard friction is quite out of the question with this tense œdematous skin. You must keep it clean with any suitable antiseptic. See also that your hands are clean. And then before you make the punctures it is well to place the limb in some antiseptic dressing, and then, after the punctures are made, wrap the

limb up in your antiseptic so as to let the fluid run into that. Then change it from time to time as it gets soaked, and change it according to the soaking. But always change it rather too often than not often enough, because you must avoid the punctures becoming seats of septic absorption. The advantage of this treatment in a bad case is that quantities of fluid drain away. Whether by a puncture or by Southey's tubes, you relieve not only the œdema of the legs, but also that of the lungs and also the ascites, for if the punctures act well fluid is absorbed from other parts and drains away through the holes that you have made in the legs. As you can often get rid of some of the œdema of the abdominal cavity and the œdema of the chest in this way, I think it is usually best to tap the legs before tapping other parts, especially if the legs are hung down a little so as to aid the flow of fluid.

If the œdema is not severe, the other means of treatment so improve the patient that puncturing is not necessary.

The next thing you often have to deal with is *lividity*. You all know the picture. The patient comes in with blue lips, blue face, blue finger tips. In such a case the right side of the heart is over distended; it cannot contract because it is over-distended. What would you do if a man's bladder were over-distended? A man comes in and he cannot pass water, and then, when you examine the abdomen and find the bladder reaches well above the pubes, you would not go on stimulating the distended bladder. What would you think of a doctor who tried, by passing an electric current, to stimulate the muscular coats of the bladder, if he had not first emptied the bladder? And the same applies to heart disease. When the patient's whole body is livid, the lips and tongue and palate all blue, obviously the right thing is to draw the blood off from the right side of the heart; and that you can do by bleeding. Take from ten to twenty ounces of venous blood from the elbow or the external jugular vein, and then the lividity passes off, the pulse becomes regular, and what is better still, your various drugs that you wanted to give, digitalis, and so on, which could not act before are of use. It was no good giving them to contract the heart, they could not contract it—but when you have relieved the distension, and the heart has sunk back more to its natural size, owing to drawing the venous blood out of it, then the drugs will act, the digitalis will act, the urine will begin to flow, and the improvement will be very striking. If for any particular reason you do not wish to bleed the patient, although it is difficult to imagine that, then you may attain some good by leeches or wet cupping.

If, after this, the lividity remain great, there is no doubt that patients are benefited by oxygen. Let them inhale it. The best way, I think, is to have a nozzle, which is connected by indiarubber tubing with the cylinder, so placed that the patient can take it up when he likes and take a few inhalations of oxygen from time to time. I do not think you will often save people's lives by oxygen, but there are a few cases regarding which I think I can say that life was saved thereby. But of this I am quite certain, that if you do not save life by the inhalation of oxygen, you make it, while it lasts, very much less distressing for the patient.

But now you will say, "You have told us all this, but you have not mentioned a single drug with which to treat the cardiac disease itself." The reason why I left drugs to the last was because they are of the least importance, in this sense, that unless you have attended to the other points just mentioned, your drugs are usually as good as thrown away. If you will attend properly to those matters of posture, rest, diet, vomiting, flatulence, constipation, sleep, œdema and lividity, then, and then only, will it be of some use your doing something for the heart by means of drugs which act on it.

Now let us suppose, for the sake of argument, that the patient has mitral regurgitation. You will say, "Give him digitalis." That is the usual thing to say, and generally speaking digitalis is a very good thing to prescribe in these cases. But remember why you give it. You know that digitalis slows the pulse. Your patient's pulse is, say, 120, and that is abnormal, and therefore it is clearly a good thing to slow it. Digitalis, moreover, makes the force of the beat greater, and if the heart is acting feebly, as it does in these cases, obviously it is a good thing to increase the force. You remember that digitalis also makes the irregular heart regular, and that is again obviously a good thing in the case now before us. Another thing that digitalis does is, that it prolongs the diastole, and the last thing I need mention is, that it constricts the peripheral vessels.

Now you must remember that in these cases there would be no regurgitation if you could get the valves together. The heart is dilated, and the valves, even during systole, are apart. By all means, therefore, give a drug that will contract up the heart firmly, and thereby tend to approximate the separated valves. It is

obvious, therefore, that in such a case, because it contracts the heart up, digitalis is a good drug.

Then, again, it is of use by contracting the arterioles all over the body. At first sight you may be inclined to say, "No, that means more work for the heart to do." But go back to your physiology, and you will remember what a poor circulation we should have if we had not a proper peripheral resistance. It is this resistance that is given by digitalis, and enables the heart to contract better than it would otherwise.

Now let us suppose for a moment that there is also mitral constriction. No drug could be more suitable than digitalis, because, owing to the constriction of the mitral orifice, the blood comes through there slowly during the diastole. You give, therefore, this drug, which prolongs the diastole, and by so doing greatly helps the circulation.

Well, now, I have told you why you give digitalis. You will say, "How do you give it?" There are many ways, and I will give you one or two prescriptions for it. In many cases there is no better than this, I think:—

℞	Tincturæ Digitalis	ʒ3
	Tincturæ Nucis Vomicæ	ʒ1½
	Caffein	gr.50
	Sodii Salicylatis	gr.25
	Syrupi Aurantii Floris	ʒ1
	Aquam ad....	ʒ10

Fiat. Mistura. Take an ounce thrice a day.

I quite admit that theoretically caffein ought not to go with digitalis. Caffein does not slow the heart or prolong the diastole, nor does it belong to the digitalis group of drugs, but it does increase the cardiac force, and experience has shown that clinically caffein goes very well with digitalis. It helps the diuretic action of digitalis, because caffein is a most powerful diuretic. The advantage of caffein as a diuretic is that it does not irritate the kidneys, as so many other diuretics do. So that we give it because it is a diuretic and because it increases the force of the beat. Some of you might think it better to give caffein citrate, but citrate of caffein, although soluble, may be precipitated when the solution containing it is stirred. It remains in solution for a time, then when the bottle is shaken the precipitate falls, and the patient uses strong language about the doctor who wrote out such a prescription. It is safer to give caffein, which is easily soluble in water, if you add salicylate of sodium to it in the proportion of 1 grain of salicylate for every two of caffein, and such a small dose as 2½ grains of salicylate of sodium cannot do any harm. The nux vomicæ acts as a cardiac stimulant too; it increases the force of the beat. The syrup is only added to flavour the mixture. You will notice I have given full doses of digitalis, but often much more than I have put in the above prescription is needed. As a rule, digitalis is not used sufficiently freely. Dr. Taylor pointed this out in a lecture published in the Gazette not long ago. Usually the mixture I have prescribed will be required oftener than thrice daily.

One little point in passing. I have known this mistake made. A man has remembered that salicylate of sodium is useful for increasing the solubility of caffein, and he has also remembered that citrate of caffein is more soluble than caffein. Therefore he gives citrate of caffein and salicylate of sodium. What happens? A compound is formed between these two which produces a most voluminous precipitate. You get the bottle filled with this compound and it is almost impossible to pour it out at all.

An excellent way of giving digitalis is as the famous combination known as the Guy's pill. One contains a grain of each of mercurial pill, powdered squill, powdered digitalis leaves, and four grains of green extract of myoscyamus. The only practical objection is that the digestive system of these patients may be such that they cannot well dissolve the pill. But still it is, without doubt, one of the best preparations of digitalis there is. The object of the squill is that it acts very like digitalis and also acts as a diuretic. Further, the object of the mercury in the pill is that it is a well-known fact that, in combination with digitalis, mercury considerably increases the diuretic action of the digitalis.

You will remember that there are some five glucosides in digitalis, and some of these have one action and some another, and really the action of the drug is the action of the drug as a whole. But the tincture, you remember, only take up some glucosides and not others. That looks, at first sight, a very serious difficulty, but it is not so serious as you would think, because in practice we find the tincture does very well. Nevertheless, if the theoretical difficulty strikes you as serious as it does many people, you can overcome it by giving powdered digitalis leaves in the pill.

It often happens that digitalis makes the patient sick. What can you do in that case? The next best drug to try is strophanthus. But you will remember that the disadvantage of strophanthus is that it does not contract the

vessels all over the body, so that you have not got so great a help to the circulation as you have got in the case of digitalis.

If, as may happen, strophanthus also makes the patient sick, there is no doubt, I think, that the next best drug to try is the tincture of convallaria majalis, the lily of the valley. It belongs to the digitalis group of drugs. There is a tincture of it prepared according to the directions of the British Pharmaceutical Conference. If all these fail to give relief you may occasionally find benefit follow by giving barium salts. The best salt to order is the chloride in half-grain doses.

This by no means exhausts the subject of the treatment of cardiac disease, but as the time is up I must postpone what else I have to say till next lecture.

Instantaneous Radiography.

BY EDWARD W. H. SHENTON.

In February, 1897, a certain gentleman having to deliver a lecture on Roentgen's discovery, wished to obtain photographs of his own chest and abdomen through the clothing, to exhibit the contents of the pockets in addition to the skeletal structures. The exposures to which he was subjected were as follows:—

The abdomen twenty and forty minutes.

The chest fifty and ninety minutes.

The Crooks tube it is stated was some three inches from his waistcoat as he lay upon the table.

That he suffered severely for his enthusiasm does not seem surprising. Marked erythema of the skin on back and chest made its appearance at once, and suspecting mischief the lecturer commenced rubbing in Lanoline, continuing this treatment for the next twelve days. Then the trouble commenced. Vesicles appeared, coalesced, and on the fifteenth day the cuticle was loose It peeled off, and to use the professor's own words, "leaving a surface exactly like that seen when the cuticle is rubbed off a dissecting-room subject, except that it was of bright red colour." Things went on from bad to worse, the discharge became sero-purulent, and about thirty square inches of cuticle were lost. Then came a turn for the better, and without going further into details, the part was healed in thirty-three days. Finally, it is of interest to note that he was not afterwards troubled with the shaving of his chin, the hair having come out by the bulbs to the touch of the razor twenty-two days after the chest exposure. Some apology is necessary for relating this harrowing story, it has a direct bearing on the subject of radiographic exposure.

Only a little over a year ago an exposure of three and a half hours was given to a patient, the subject of renal calculus. The trouble caused by the calculus seems to have been but a trifle compared with that occasioned by the X rays. This form of counter irritation, however, has its drawbacks, and the ingratitude of the patient took the form of legal proceedings. As these cases are typical of a host of others, recorded and unrecorded, it is with a sigh of relief that the radiographer finds exposure daily becoming shorter and dermatitis a thing of the past. For a year at least it has been practically impossible to obtain any skin reaction with the rapid tubes in use for screening or photographic purposes, which have been sufficiently powerful to penetrate any portion of the body in five minutes. No doubt harm might have arisen even with this form of tube had the length of time been hours instead of minutes. When exposure is further reduced to seconds instead of minutes it does not seem unreasonable to suppose that dermatitis, X ray, burns, or whatever the evil is called has disappeared for ever. The word instantaneous has been used so loosely in photography that its application to radiography can be excused on the grounds that it is to inexact to mean anything. In photography it once meant seconds, now thousandths of a second. It will be as well therefore to explain that, by the expression instantaneous radiography is meant, radiographic exposure that does not exceed thirty seconds, and may be as rapid as a hundredth part of a second.

Advantages accruing from this rapidity may be considered from the patient's and operator's points of view. A short exposure will save the time of both. The terrors of dermatitis so dreaded by nervous patients have been entirely removed. At a time when it was necessary to keep the patient immovable for twenty minutes at a stretch, it was too much to expect that this could be repeated indefinitely until a satisfactory negative was obtained. The enthusiasm of one or other would abate. Then again, failure in one attempt meant another twenty minutes or more, with possibly another failure at its termination. Hope deferred maketh the heart sick, and when sick a man does not shine in radiographic diagnosis. There has been no spur to radiography so effectual as the substantial reduction in exposure times; but it surpassed the hope of the most sanguine that the word instantaneous would be applied with truth to X-ray science in this century. Without going into technical details too deeply, it must be mentioned that this advance has been made through improvement in the tube, and not by any photographic device. This is as it should be, for with the bettering of the tube comes not only shortening of exposure, but vastly increased screening capabilities.

Photography has attained such a degree of perfection that it is unreasonable to look for marked improvement in that branch. Intensifying screens, emulsions with fluorescent substances in the composition, and the like will not bring such practical usefulness in their train as increase of power in the rays themselves. It is therefore highly satisfactory that the X-ray tube is responding to the care and labour that has been expended on it. The new tube has special characteristics in that it is larger and of more simple construction than any yet made. Any further details can be obtained from Mr. Dean, of

Fig. 1.

Fig. 2.

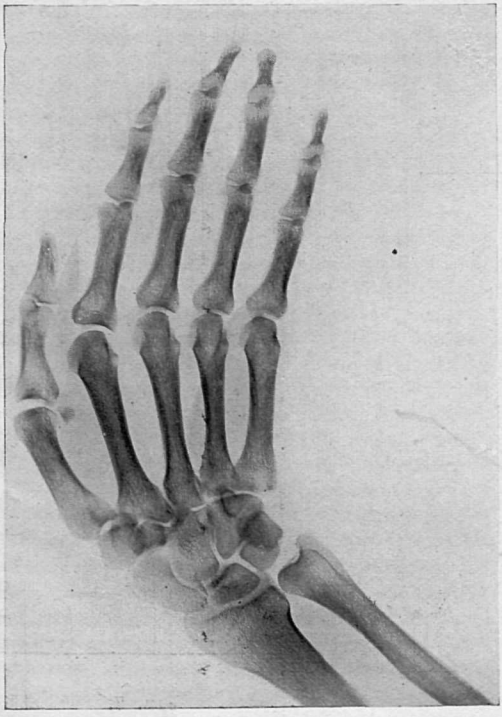

Fig 3.

Fig. 4.

INSTANTANEOUS RADIOGRAPHY.—By Edward W. H. Shenton.

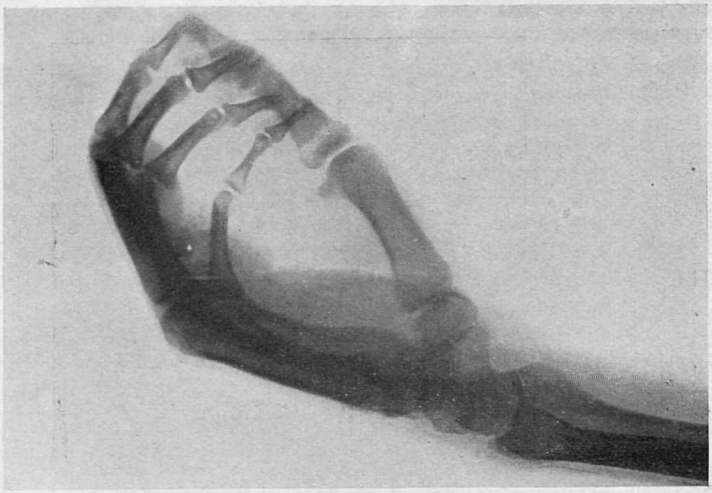

FIG. 5

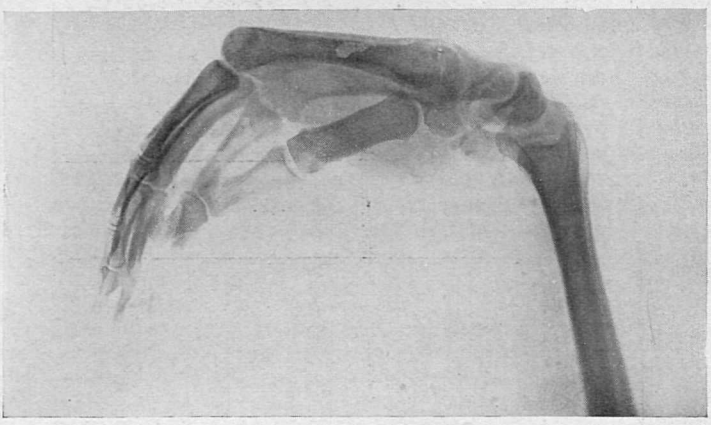

FIG. 6.

FIG. 8.

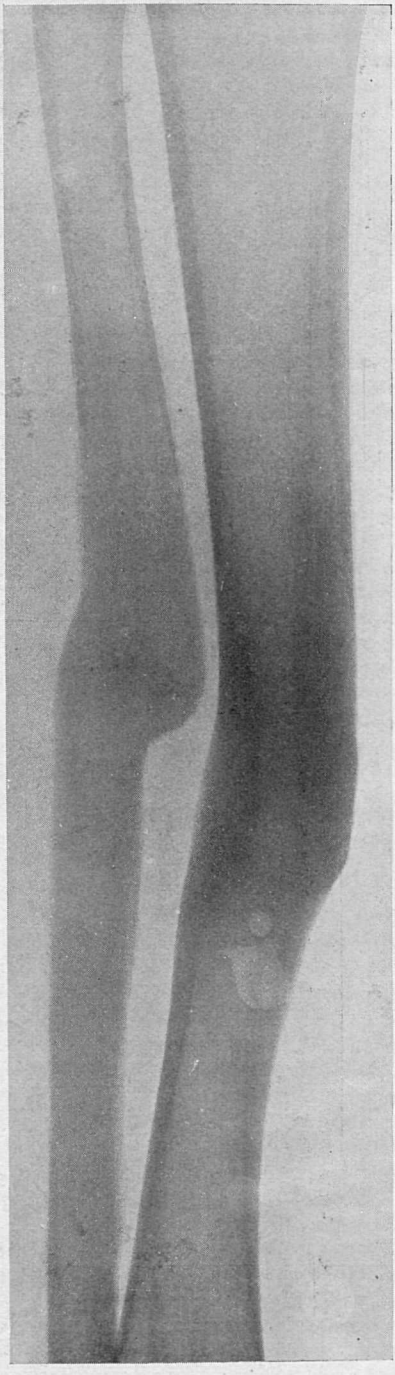

FIG. 7.

Hatton Garden, who has taken great trouble to work out, from my suggestions, a tube suitable for rapid radiography. Space will not allow of a careful statement of what may be done by rapid exposure. The radiographer is almost in the position of the present-day photographer in that he can catch and record a phase of a changing scene. The accompanying illustrations will justify this remark when it is understood that all the skiagrams of the hand seen in Figs. 1, 2, 3, 4, 5 and 6 were taken within a space of time not exceeding thirty seconds. It merely remains for suitable mechanism to be constructed to see the movements of a limb as in a cinematograph, a veritable living skeleton.

For hands and feet the exposure can be as rapid as it is possible to make it, the $\frac{1}{100}$ of a second perhaps.

It is at once seen how life-like the positions appear when contrasted with those which have been laboriously arranged and kept still by sand bags. The lateral movement of the wrist-joint illustrated in the first three pictures can be appreciated at a glance.

Is there any other existing means whereby the same correct idea could be formed of the relative positions of the various bones involved in this movement? This should surely make the instantaneous radiogram par excellence the method of illustrating anatomy books of the future. A great drawback to radiography up to the present has been the fact that the part radiographed has almost always moved a little, rendering the definition imperfect. To remedy this defect tubes giving specially fine definition have been constructed, though how these should avail is not very obvious. No amount of definition in a photographic lense will counteract the effect of an exposure that allows the subject photographed to move. It is, therefore, a pity that so much should have been said about the definition of tubes.

Take a radiogram of a dead limb with a tube of no pretentions and compare it with one of a living part taken with a tube supposed to give great definition. The sharpness of outline of the former will far and away exceed that of the latter, if, in both cases, long exposures have been given. Arterial pulsation and unconscious muscular movement are the factors that blurr a radiogram, and the obvious remedy is to shorten the exposure. This, then, points to another use of instantaneous radiography, the securing of definition. It must not be supposed that hands and feet are the only parts amenable to rapid exposure. The abdomen of a fairly stout individual can be penetrated in a space of time varying from twenty to thirty seconds, and the resulting photograph is more satisfactory than that which has been obtained by a five minutes' exposure. This is undoubtedly due to the fact that a patient can hold his breath for so short a space of time and the radiogram is not affected by respiratory movements. For a chest a period of seven seconds is often ample, and the special advantage of this rapidity is seen in the case of dyspnœic people, who cannot control their breathing for a longer time. The tube that will take an abdomen in thirty seconds will often allow a renal calculus to be seen *in situ* upon the screen, a most striking and useful feature. Within the last few days a case in point has been examined in this manner. The diagnosis lay between tubercular kidney and stone. A large mass moving several inches during respiration could be seen in the kidney region of the left side. This fact alone persuaded both patient and surgeon that an exploratory operation was necessary. A large branching calculus was removed. On account of the extensive movement of the calculus while the patient breathed, it seems highly probable that an ordinary photographic exposure of some minutes would have shown nothing of a definite character.

Fig. 7 is a leg a few months after a severe fracture of both bones, the interest lies in the exposure having been but two seconds. The tube in this instance was a good distance from the plate, nearly eighteen inches, and as the exposure increases with the square of the distance it is easy to see how much even this short time could have been reduced. Perhaps one of the most suprising examples of rapidity, to those who have had some experience of the difficulties of the radiography of the deep tissues, is to be found in the case of the hip-joint of a well-built young man, an officer, who was shot eleven times in the first engagement of the present war. Upon screening a bullet was clearly visible near the neck of the fermur, and it, together with the whole hip-joint, was recorded in ten seconds exposure. The hip-joint, it should be remembered, is the densest part of the body from a radiographer's point of view, and a good skiagram of an adult pelvis is a rarity. There are occasions when the part of which a radiogram is desired is so extremely painful that the patient will not allow a prolonged manipulation; it will then be of great service if by means of a flash exposure a photograph can be secured. The foot depicted in Fig. 8 was such a case owing to suppuration resulting from an unsuccessful operation for the removal of the needle. The exposure was momentary. Rapid exposure in photography is chiefly appreciated by those who have to deal with children. The same can be said of instantaneous radiography. Though the majority of children take kindly to the X-rays, and are more amused than frightened, yet there is the occasional one who is proof against blandishments and to the end of the operation is about as manageable as an excited snake. For such a being instantaneity is essential and will take the place of the more troublesome and hazardous anæsthetic.

Papers by Guy's Men.

Addison's Disease and Leucoderma. By Sir Samuel Wilks, M.D. Lond., F.R.S.—*Lancet*, 28th July.

Medicine as a Science and Medicine as an Art. By Philip Henry Pye-Smith, M.D., F.R.C.P. Lond., F.R.S.—*Lancet*, 4th August.

A case of Aneurysm of the Abdominal Aorta pointing posteriorly, in which the initial symptoms were those of Chronic Colitis—*British Medical Journal*, 28th July.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Mr. Steward Replies.

DEAR SIR,—May I be allowed through the medium of the GAZETTE, to thank the Students of the Hospital for the very handsome present that they have sent to me, on the occasion of my marriage. I very much admire the present itself and most sincerely appreciate the great honour that has been conferred upon me by my many kind friends among the Students in presenting it to me. The kindness and consideration constantly shown me, have always made my work in the dissecting-room a pleasure, and I cannot allow an opportunity like this to pass by without expressing my regret at leaving the dissecting-room, and my gratitude to all my past pupils for making life so pleasant for me during the time I have been a demonstrator of anatomy.—I am, yours sincerely,

FRANCIS J. STEWARD.

Guy's Roll of Honour.

DEAR SIR,—I am writing to ask you if any steps have been taken to perpetuate the memory of those Guy's men who in this present South African campaign have either succumbed to disease or have been killed in action. Guy's roll of honour has been added to by the names of Onraët, Whicher and Fitz-Hugh, who, at their country's call, came forward and gave not only their skill but their lives in order to alleviate the sufferings of the sick and wounded. Surely we, as Guy's men, should be the means of handing down their names to future generations for the honour of our Alma Mater. I would suggest a brass tablet with their names inscribed in the Chapel. Kindly let me know if this can be carried out as I should like to send my contribution,—Believe me, yours sincerely,

"POCKET CASE."

Nursing News.

MATRON'S OFFICE.

The announcement that Sister Clinical, Miss Hermann, was leaving Guy's on August 1st, was received with much regret by the whole of the Nursing Staff, and we wish her every success in the new work she is taking up after a short holiday. Miss Oxford, who has had charge of Philip ward, is now Sister of the Clinical wards, and Miss Godby (Sister Lydia), who has had charge of the women's surgical wards, under Mr. Howse, will be transferred to Philip ward on her return from holiday. No appointment will be made to Lydia ward at present; Nurse Helen Newton will take charge of the ward for the remainder of her nine months' agreement, after taking her L.O.S. Diploma, and the Matron hopes by that time that one of the three sisters now working in South Africa, who were promised a vacancy if possible, will have returned to England.

On Wednesday, August 1st, Nurse Enid Newton, Head Nurse in Bright ward, left the hospital on completing her three years' training, and Probationer L. Collins has been appointed Head Nurse in her place.

On Thursday, August 2nd, Nurse R. Daniell left the hospital, and Probationer Lowthin has been appointed to succeed her as Head Nurse in Dorcas ward.

On Friday, August 3rd, Nurse Custance left the hospital, and Probationer Goodwyn has been appointed to succeed her as Head Nurse in the theatre.

Davies-Colley Memorial Fund.

LIST OF FURTHER SUBSCRIPTIONS.

	£	s.	d.
Amount already acknowledged	247	3	0
T. Sutton Townsend, Esq., J.P.	5	5	0
Dr. J. H. Bryant	2	2	0
F. Durham, Esq.	2	2	0
R. H. Hughes, Esq.	2	2	0
A. H. Tubby, Esq., M.S.	2	2	0
Robert Harris, Esq.	1	1	0
Wilfred Howard, Esq.	1	1	0
E. C. Taylor, Esq., M.S.	1	1	0
E. H. Greaves, Esq.	1	1	0
W. Carling, Esq.	1	1	0
Holland Wright, Esq.	1	1	0
Dr. D. Elcum	1	1	0
C. W. Booker, Esq.	1	1	0
F. T. Paul, Esq.	1	1	0
Dr. C. D. Muspratt	1	1	0
Dr. Theodore Fisher	1	1	0
Dr. A. S. Wohlmann	1	1	0
Dr. John Tanner	1	1	0
Herbert Lucas, Esq.	1	1	0
Percy Warner, Esq.	1	1	0
T. S. Jackson, Esq.	1	1	0
B. F. Pendred, Esq.	0	10	6
E. W. Du Buisson, Esq.	0	10	6
G. H. S. Daniell, Esq.	0	10	6
A. Leigh Allworth, Esq.	0	10	6
Charles Jephcott, Esq.	0	10	6
J. P. Watkins, Esq.	0	10	6
Geo. J. B. Stevens, Esq.	0	10	6
G. F. Hugill, Esq.	0	10	6
Frank Cowan, Esq.	0	10	6
H. Leader, Esq., M.D.	0	10	6
D. W. Thomas, Esq.	0	5	0

THOS. G. STEVENS,
Hon. Sec.

Passim.

From the point of view of the hospital in general, we are never confronted with a slack season; it is only when the time arrives for the chronicling of things done that the appalling lack of current material becomes evident. Our situation in the Borough prevents us from expatiating on the glories of giant gooseberries, grown on the premises and certified by a clergyman, and we are too far inland to be appreciably affected by sea serpents, however healthy and well authenticated. We thus find ourselves stranded on the bare-rock of the commonplace, and needs must lie there until a spring-tide of awakened interest floats us into deeper and more comfortable waters. However, the weather is still left us, and if in our last issue we baked under the influence of an anticyclone, at the present moment we are revelling in gales, thunderstorms, and waterspouts, and find ourselves calculating the advisability of going across to the Medical Buildings without oilskins. Thus even the present monotony of life is broken into by the ever-changing kaleidoscope of the weather.

The annual report of the Earlswood Asylum for Idiots is of interest from many points of view. When regarded from the purely philanthropic standpoint, it is a matter for congratulation that this excellent institution has suffered but slightly from the patriotic war fund drain. The economic value of the Asylum is amply demonstrated by the balance-sheet showing the profit and loss of each shop. Only one, that of the mat and mattress makers, shews a loss, and the total profit on the six shops amounts to five hundred pounds. The table of "trades" of inmates might be used as an indication of the relative intellectual values of various callings. In this way housework stands last, claiming the greatest number of followers, while shoemaking and "hair-picking" run it very close. Gardeners and farmers, possibly agricultural labourers, come next, and are followed by shoeblacks, carpenters and tailors. Quite high up on the scale are compositors, printers, basket makers, bakers, and kindred trades, while wood carving, turning, book-binding, chair-caning, and so forth, claim only one votary apiece. The deduction to be drawn of the relative intellectual position of the trades of boot-making, and bookbinding is thus obvious, though possibly incorrect.

Nearly every hospital journal has now letters from alumni at the Front in one capacity or another, and nearly every hospital has had to mourn the loss of one or more of its fellows. In the *London Hospital Gazette* there is a detailed description of the Imperial Yeomanry Hospital, which must be pretty familiar to most of our readers by now, and information concerning the doings of London men, but the one paragraph which appeals to us most, coming as it does from an entirely outside source is as follows: "Dr. Fitz-Hugh, of Guy's, has just succumbed to a severe attack of typhoid; his death leaves a gap in our ranks that will take a long time to fill up; he was the life and soul of the camp." Everybody who knew Fitz-Hugh will realize the absolute truth of these few lines.

In another part of the same paper, an opinion is expressed with which we most heartily concur. Speaking of the Inter-Hospital Athletic Shield, the *London Hospital Gazette* says, "We should like to see the rules, with regard to winning the shield, altered somewhat next year. The system ought to be worked on the principle of so many marks for the first, second, and third places, and the hospital obtaining the greatest number of marks should take the shield. Had it been so this year, Guy's would easily have been first, with their three firsts and six seconds. It obviously is not quite fair that a hospital should send up but two men, neither of whom competes in any of the running events, and yet these two should, by winning a couple of firsts apiece in other events, still take the shield."

We have received an advance copy of that excellent little publication, the Guy's Hospital Clubs' Union Year Book, familiarly known as the "Blue-book." We notice with pleasure that this cheery little fellow is actually putting on fat, principally in the "list of members" department, and we also notice that its circulation has increased by two hundred and fifty over that of its brother of three years ago. All these point to a better condition of health in the Clubs' Union, although the balance-sheet shows that the balance in hand is less this year than last. The contents of the Blue-book are familiar to everyone. They are all set forth, with one or two additions, as in last year's issue, and even the very harmless joke about the Reports is still cracked merrily. It used to be stated that the Reports were "now published annually"; this is modified to "periodically," and on looking up the exact connotation of that word, we find

"occurring at *regular* intervals." So the jest wheezes on.

Congratulations to Mr. Basil Hall on gaining fifth place in the examination for Surgeonships in the Royal Navy. Mr. Hall now goes to swell the ranks of the many good men who have entered the services from Guy's, and we trust that his long experience as a volunteer ashore will stand him in good stead when he comes to command the handy-man afloat. Anyhow, we wish him good luck and a good ship.

The Council of the Guy's Hospital Nurses' Recreation Society gave a series of "At Homes" at Honor Oak Park on the 23rd to 26th ult., and by this means informally opened the new Nurses' Recreation Ground, which now stands in the same relation to the Nurses' Club as does the Hospital Ground to our own Clubs' Union. Although not nearly so large as the more familiar Honor Oak Park ground, the new comer can claim a considerably greater share of natural beauty, and in addition has a singularly picturesque club house. Placed on the side of a rather steep hill, the ground is of necessity cut into terraces to admit of level tennis courts and croquet lawns. These, with plenty of green foliage and massive spreading beeches, form a most pleasant relief after the endless brick and mortar of the Borough. The nurses are certainly to be congratulated on the acquisition of a most delightful recreation ground within a practicable distance of the hospital.

Dr. Harford Battersby, the Principal of Livingstone College, has desired us to call the attention of our readers to the scheme which has been projected for acquiring by purchase the freehold of Knott's Green House, Leyton, and adapting it for use as Livingstone College, thus forming a permanent memorial in London to David Livingstone. The objects of this college may not be generally known: briefly, the idea is to give the missionaries destined for service abroad an elementary knowledge of medicine and surgery. It is not intended that they should supplant the medical missionaries, who possess a proper legal qualification; indeed, it is expressly stated that the students of this college are forbidden to call themselves by this title. The intention is that the missionaries, who are frequently located hundreds of miles from medical aid of any description, shall be able to deal with the casualties that may arise in something like an intelligent manner; that is, to fulfil the duties which the native expects of the great white man. The college can only do good; in many cases its instruction will prove invaluable, and as such, this scheme is worthy of the support of the charitably disposed.

We take the following extract from the *Star*:—"Dr. William Alfred Elliston, the President Elect of the British Medical Association for 1900–1901, who last night entertained a distinguished company at Stoke Hall, his home at Ipswich, was born in 1840 in that East Anglia town, where his father had been in practice for many years as a surgeon. Dr. Elliston, who was educated at Guy's, has himself practised at Ipswich as a general physician since 1863, and is senior surgeon of the East Suffolk Hospital. He is actively interested in the British Medical Association, having been a member of the council for many years. He is a keen golfer, and captain of the club at Felixstowe, where he has a seaside cottage."

We publish in this number an article by Mr. Shenton on "Instantaneous Skiagraphy," with some specimens of his work in this direction. Since the adaptation of the Roentgen system to surgical diagnosis, we have always at Guy's managed to keep well in the van of all progress in this science. The very important results which Mr. Shenton has obtained and described in his paper have already demonstrated their utility in this hospital, and it is a matter for congratulation that, with our radiographic department in its new quarters, we now stand second to none in this branch of hospital equipment. By a curious irony of fate, Mr. Kirkman, who has worked in conjunction with Mr. Shenton, and who went to the Front expressly as a skiagrapher, has been employed nearly the whole of his time on purely medical work, and is only now, at the end of the campaign, in a position to put his special knowledge to good account.

Considerable excitement was caused in the neighbourhood of Maze Pond last Wednesday by the appearance of a motor car outside the college gates. The crowd which springs suddenly from nowhere on any occasion of special interest, was moved to rapturous applause when two externs appeared from the college, with bag in hand, and with an obviously

assumed air of nonchalance took their seats in the conveyance. Progress was somewhat impeded by the large number of children who found resting places on the gear cover and who resisted all efforts at dislodgment. Up to the time of writing the ultimate fate of these pioneers in locomotion has not yet reached us.

In the *St. Bartholomew's Hospital Journal* for July, appears the second of a series of articles, "Selecta ex Scriptis," from the pen of Mr. Womack, dealing with the answers of candidates to examination questions, in this case, on matters physical. One candidate defines a "second" as "the smallest portion of time conceivable to human beings without artificial means." Another gives the following novel method of estimating heat loss: "To find the amount of heat given out by a rabbit in six hours, wrap the rabbit in flannel for six hours and quickly removing the flannel wrap it round a metal vessel filled with water. Find the heat thus imparted to the water." But the *bonne bouche* is found in an answer dealing with the Toricellian Vacuum. "'Nature abhors a vacuum.' The Pope is an old gentleman who lives at Rome in a vacuum."

In the interests of Science, we publish the following letter as received from S. Africa.—

Hartley Hills, Mashonaland, S. E. Africa,
12th June, 1900.

The Principal Resident Medical Officer,
Guy's Hospital, London.

Sir,—I never quote or mention a *cure* until I have proved it one. The knowledge I impart is perfect and for sale at its fair value. I have to live and am entitled to my fees:—"Opthalmia," its cause. The ailment is caused by the eyes of a subject taking in too much light and glare, and retaining it, causing great distress, partial blindness, inflamation, etc. Treatment and cure: The eyes to be bathed with soft face sponge and warm filtered water three times a day. The patient to be kept in total darkness till the cure is brought about. The patient to be caused becoming accustomed to light again gradually.

W. K. STEER.

"Reply me please."

Prizes.

SECOND YEARS' DENTAL STUDENTS, 1900.

The Prize of the value of £15 has been awarded to Mr. E. W. Corfe, and Certificates to Messrs. H. L. Dent and W. E. Meads.

The next issue of this Gazette will be on Saturday, September 1st.

Some Notes on the Imperial Yeomanry Hospital.

Imperial Yeomanry Hospital,
Deelfontein,
July 2nd, 1900.

It is hard to think that we are in July. Really it seems much more than five months since we were getting ready to start in London. Though we are in mid-winter it is so warm in the sun that we are able to carry most of the patients out into the open air for some hours each day. They like it, and there is no doubt it does them good.

Christian De Wet is not broken yet, but surely it cannot be many days before our many divisions which are all round him bring about his downfall from his high pedestal as the one efficient discomforter left, and so put an end to the war. There ought to be a big bag soon, and there is an impression that Botha will surrender when De Wet is settled, and that then the resistance to Lord Roberts will fizzle out quickly. We hear that Lord Kitchener has gone down to have a go at this most sporting of generals. There is, in fact, a general feeling manifest in this camp and among those who come into it that it is all over, and the chief question on everybody's lips is how soon we shall get home. "Impending dissolution" fairly defines the feeling that pervades the hospital. The Colonials who came on to our staff in various managerial capacities are all anxious to get away and to return to their permanent posts. Our dental surgeon and one of our dressers (Hay) have already gone home. Blathwayt is in the isolation hospital, as I told you, and we have made him the medical officer in charge there. Poor Fitz-Hugh is dead, and two of our doctors (Greenfield and Elliot) are still in the wards recovering from enteric so that the number at mess has been somewhat attenuated of late. Breeks, who came out as one of the dressers, but who is a qualified medical man, has been promoted to fill Fitz-Hugh's vacancy.

I am thankful to say that the epidemic of enteric is rapidly diminishing, both in the number of its victims and also in the virulence of the type of the disease. This is what we have been hoping for ever since the cold weather set in. The result upon the work in the various hospitals is immediate and very marked. The report from Bloemfontein is that already the hospitals there are half empty, and certainly the authorities show nothing like the anxiety they did, even two or three weeks ago, to fill up our vacant beds as soon as we return them. Indeed, we have not taken in a train-load since the Mafeking sick and wounded arrived a fortnight ago, though small parties of yeomanry still drop in with great regularity every day, almost, one might say, by every train. In spite of this we have been quite busy with surgery up to the middle of last week. The various hospitals which for some weeks past Surgeon-General

Wilson has had ready packed in trucks to be shot up to the stations north of Bloemfontein, have not all of them got through even yet. The difficulty is not one of deficient medical resources but of deficiency of transport; for, what with the repeated interruptions inflicted by De Wet upon the railway service, the worn out condition and the small number of the engines, the delays at the deviations where a bridge has been blown up, and the scarcity of fuel and water, it requires the entire energy of the railway staff to keep the army fed.

My rubber, who came out with me, had to spend a week in hospital lately, and his services were very much missed. He pays from thirty up to sometimes as many as fifty visits every day, and has been so useful that we have sometimes kept cases in the hospital much longer than we should otherwise have done so that they might benefit from his attentions.

Chilblains have been a great nuisance to the sisters recently. I never saw such bad ones as they have had out here, particularly the sisters in the enteric huts, for they have to be perpetually wetting and drying their hands.

It is rather late in the day, and I should have mentioned it long before, for I had no notion how much loss was incurred by friends at home labelling the parcels they kindly sent to South Africa with a full indication of the tempting nature of their contents, but the best way is for only a general description to be put on the parcel, *e.g.*, gifts for the troops, rather than tobacco, cigarettes or sweets.

I told you before that people commandeer in this happy land, and also most people are making collections of any trophies they come across. Mafeking seige stamps are very scarce and are considered cheap at thirty guineas the set of nineteen, and the seige paper money sells readily at twenty guineas for notes, the total face value of which is two pounds six shillings.

Talking of Mafeking, we have, as you know, a large number of men here who went through the seige, and it is rather amusing to hear their criticisms of the inflated accounts which reach their ears from outside of the doings of some of their fellow captives during the seige. Every one of them is loud in praise of General Baden-Powell.

The metal badges of the hospital have arrived and were distributed on Saturday by Lady Chesham to the entire staff. Also the name boards of the wards and beds have come, and are being stuck up as quickly as possible.

Two names which I appropriated for two of my wards are the "Wills" and the "Article Club," because it was owing to some friends of mine that they were endowed, Sir Frederick Wills being personally responsible for the first, while his son, Arthur Wills, prompted the generous efforts of the Club which equipped and therefore named the second. The latter was only just starting his good work when we left England, and I am very pleased to see that he succeeded in carrying through his project of equipping the whole ward.

During the week also there has arrived from the Royal Army Medical Corps Fund in London a welcome present of pipes, tobacco, and clothes for each of the N.C.O.'s and men of our staff. It gave them great pleasure, for it showed them that they were not forgotten, and, indeed, I do not think that Her Majesty's forces contain any harder or more devoted workers than the hospital orderlies. Their position is one of considerable danger. I know one hospital which has lost no less than thirty from enteric out of less than two hundred, and their work in the wards is exacting and continuous. For them there is no such thing as a halt (unless, indeed, they get sick themselves) from the beginning of the war to the end, and they deserve all the kindness and recognition which friends at home can secure for them.

I think I told you some time ago that my wife had kept some of the patients occupied by starting essay competitions. More lately she got one or two of them to try their hands at sketching, and some others at wool work. Both of these pursuits have "caught on" to such an extent that it takes up all of her spare time to keep the hardy warriors supplied with needles and wool and canvas and other necessaries, and it looks most quaint to see them sitting up in bed stitching away for all they are worth. Some of them rush through a pair of slippers in an incredibly short space of time. Others, again, devote their entire attention to the various games that have been sent out from home. Cards form perhaps the most popular of these diversions, and when we move the patients on their reaching convalescence from the huts to the bell-tents, and subsequently into the trains for Cape Town, they do not fail to provide themselves with means for whiling away the time, so that there is a perpetual demand for a fresh supply of these smaller articles of diversion.

ALFRED D. FRIPP.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

NOTICES.

J. J. C., BRIDLINGTON.—This tumour consists of fibro-fatty tissue in which are embedded ducts and acini of glandular tissue like that of the breast. Some of the ducts are dilated and filled with secretion, and there is a little recent inflammatory change around them.

E. S., FULHAM.—This is a case of chyluria due to the filaria sanguinis hominis (probably var:—nocturna). The urine was centrifugalised, and four or five of the filariæ were found in the deposit. Complete identification is impossible as the filariæ are dead. Blood films taken at night and during the day should be examined.

H. B., BUILTH.—No tubercle bacilli were found in the sputum.

PATHOLOGIST.

The Prevalent Diseases of the Campaign.

No. 8 General Hospital,
Bloemfontein.
June 9th, 1900.

Having now had a good opportunity of studying large numbers of patients suffering from medical diseases in Bloemfontein, men who have been sent from most parts of the Orange Free State, now Orange River Colony and the Transvaal, I think a few words on the different ailments, with their local peculiarities, will be interesting to most Guy's men and others interested in medical conditions.

Firstly, a word or two about No. 8 General Hospital, to which I am attached. Shortly after our arrival in Bloemfontein on April 9th, 1900, we pitched our camp on a gently inclining ground to the north-east of the town; a very excellent position from an hygienic point of view, were it not for numerous decomposing horses lying on the veldt, which had been left by the Boers unburied, and from which, with the wind in our direction, came a most unmerciful and insanitary stench.

We had hardly pitched our marquees and tents, which were rapidly filled with patients from the field hospitals and other temporary establishments in the neighbourhood, when we had orders to be prepared to receive many more patients in excess of those for whom the hospital was intended originally to accommodate. 150 more bell-tents were rapidly erected, and the sick began to arrive. Shortly before Lord Roberts started on his march into the Transvaal, all the field hospitals had to be emptied of patients in order that they, the hospitals, should be able to proceed with the main advance. On one day, when I happened to be "Orderly Officer," we admitted as many as 500 patients, the majority suffering from enteric fever; some very ill. Two of these poor fellows had died on the way, having been forty-eight hours in bullock waggons with very little nourishment, and none but the roughest medical and nursing attention. It was a day one will never forget. After having managed to stow them away as best one could, in marquees containing beds if very bad, and in bell tents (six in each on the ground) if a little less ill, I spent the whole of the afternoon walking round the tents with two "orderlies" carrying buckets of milk. I had a bottle of brandy under my arm, and a hypodermic syringe containing liq. strychninæ in my hand. We managed to give a drink of milk to each, and to the worst cases we administered one or other of the stimulants. At midnight we were still engaged trying to get out of store blankets for those who had had the misfortune to lose theirs on the way. Two men, I remember, had such dry mouths which were so thickly coated that their tongues were firmly cemented to the roofs of their mouths, and in one case it was several hours before it could be released by the aid of moisture and applied force. Both these patients, strange to record, recovered.

The strain of work about this time, and for the following month, was very heavy. We had only the same number of medical officers, sisters, and orderlies, originally intended for 500 patients (there were between 1500 and 1600 in hospital) and several of these were down with diarrhœa and other objectionable complaints. We are now gradually emptying the hospital by sending convalescent patients down to Cape Town, and, as but few are arriving here, the stress of work is much less heavy and we are able to give more attention to the individual patients.

Medical officers, sisters, and "orderlies," have had their share of illness. Out of our complement of eighteen medical officers, three are now in different hospitals in the towns with enteric fever, one has been invalided with very severe dysentery to the base, and we have all, without exception, suffered from troublesome and painful diarrhœa, with which several of us have passed mucus and blood, so simulating mild forms of dysentery. The chaplain has gone off to recruit his health after an attack of dysentery. Five of our sisters are down with enteric fever (one convalescent) one with dysentery. One died about ten days ago with acute dysentery. Of the "orderlies," out of a number of 120 nearly thirty are now in hospital with enteric fever and dysentery, and four have died. Since the cold weather has set in there are fewer catching these complaints, and the enteric is becoming certainly less severe; whereas six weeks ago we were having a mortality of from eight to ten patients a day, we have now only about four or five.

Enteric Fever.—This is by far the most common disease with which we have to deal, nine-tenths of all patients in hospital suffering from typhoid. The course of the disease is in a large number of cases quite different in many aspects to the enteric fever we see at home. The rash which makes its appearance between the fourth and the twelfth days of the illness, I hold to be present in a very heavy percentage of all cases, in fact, I will go so far as to say that it is extremely rare for it to be absent. If the abdomen, back, chest, thighs, and arms, are searched every day between the fourth and twelfth days of the disease I believe it will be found in at least 98 cases out of every 100. There are generally only a few spots about the abdomen, chest, and loins, but in a few cases (about two per cent.) the rash is very profuse, and in one case we have now in the hospital the patient is covered over the whole trunk with a beautiful rose rash consisting of many thousand spots. There are spots on the neck, behind the ears, on the arms, wrists, thenar eminences of hands, legs, and soles of feet. This is the most profuse rash I have seen, but I have come across three or four nearly as extensive. This patient is only moderately ill.

It is quite rare, unless there is some peritoneal trouble, to get abdominal distension, pain in the abdomen, or much limitation of abdominal movement.

The spleen can be felt in about thirty per cent. of all cases, but on all patients on whom I have made autopsies, this organ has been large and soft.

There is generally diarrhœa, and I have only on two occasions found constipation troublesome.

A distressing and obstinate symptom which occurs, more especially amongst those having high temperatures, with

dry tongues and sordes about the mouths, is sore throat; it is often the only symptom which troubles the patient. Gargles seem to have no satisfactory effect upon it, and it gradually passes off as the temperature falls; but this is by no means always the case, and occasionally the pain and distress continue long after the temperature falls and the patient is otherwise comfortable. On visual examination all that can be seen is redness and swelling of the tonsils and pharyngeal mucous membrane; in some cases the tonsils are very large, but there is no ulceration. Unfortunately we have not a laryngoscope at our disposal, so it is impossible to examine the larynx, but I doubt whether any of these cases are associated with laryngeal ulceration.

Rheumatic pains in the joints—in many cases actually simulating acute rheumatism, in that the pains leave one joint and attack another—are frequent in the early stage of the disease, and many patients diagnosed amongst those admitted as rheumatic fever, have turned out to be enteric. Bronchitis and pains in the ears also occasionally give rise to errors in diagnosis in the early stages.

Hæmorrhage, although not very common, has proved to be a most formidable complication, and has been followed by a mortality of about 50 per cent. The most satisfactory treatment has proved to be opium and starvation for twenty-four hours.

Pleurisy is comparatively common, and occurs in about 15 per cent. of all patients. In a few cases it has been very extensive, and on one or two occasions followed by extensive pleuritic effusion. I have neither seen nor heard of any case of empyema as a complication. Pneumonia has occurred in about twelve patients, and has been followed by fatal results in all but two. It has generally come on from about the twelfth to the fourteenth day of the illness, and in the two cases I have had an opportunity of watching, this complication has been of the most severe character. In both cases rigors occurred about thirty-six hours before death, and physical signs of consolidation only made their appearance about twelve hours before the fatal conclusion.

Perforation and peritonitis are comparatively rare (about 2 per cent. of all cases), and this seems the more strange, as unless the patients are very ill, owing to the scarcity of "orderlies," they have to get out of bed every time their bowels are open.

Deafness (severe, moderate and slight) is very common, and occurs in more than 30 per cent. of all cases; it generally comes on quite early in the disease, and only commences to improve with convalescence. Syringing the ears with warm boracic lotion leads generally to an improvement in the hearing, and greatly comforts the patient. Of suppurative otitis I have only seen one case, but have heard of several more in the hospital. Toothache, due to carious teeth, is common, and it often comes on in patients who, although they have had decayed teeth for many years, have never suffered pain from them before. It is often of a most severe character. Extraction of the teeth generally relieves the trouble. In many patients neuralgia, and even general headache, which are commonly put down to the typhoid toxæmia, are without doubt due to carious teeth, and the symptoms are instantly relieved by their extraction. Too much stress, I feel, cannot be laid upon this fact, as often phenazone and other depressants are given ad lib. without giving relief, when a pair of dental forceps will do all that is required,

Parotitis is fairly common. One patient now in hospital has enormously swollen parotid glands, and cannot separate his teeth more than one-eighth of an inch. *Orchitis* is rare; I have seen two cases.

Femoral thrombosis is a fairly common complication. I have had four cases under my care, one with thrombosis of both femoral veins. Major Birch, R.A.M.C., tells me that in his experience as many as 15 to 20 per cent. suffer from this complication. This certainly is not so frequent in Bloemfontein. It often comes on in quite early convalescence, and is often accompanied by very little œdema.

Difficulty and pain in passing urine is frequently a trouble, but this passes off with early convalescence, and although a very painful condition, does not appear to be associated with evil results.

Amongst sequelæ, rheumatic pains, principally confined to the lower extremities, seem to be the most common, and there is a peculiar condition which comes on about a week after the temperature has been normal, and in some cases when the patient has been up and about for a few days. It is severe pain in the soles of the feet, which comes on in paroxysms, generally towards the afternoon and evening, often causing the patient to cry out with pain, with or without putting his foot to the ground. Several medical officers have told me they have frequently observed the same condition. What would appeal to all of us as a cause would be the pressure of the bed-clothes on the fore-part of the foot during a lengthy illness, but the fact that in many cases the patient has been up and about for many days before the pain attacks him, and also, that relief of pressure by means of a cradle causes no apparent improvement, seems somewhat to contra-indicate this.

Lumbago, sciatica and mental affections are occasional sequelæ.

About relapses I can say nothing, as I have not had an opportunity of seeing one case, and they must certainly be very rare indeed. This is the experience of others with whom I have conversed. Convalescence is generally rapid, and many patients have expressed themselves fit for work in a fortnight after the temperature has been normal. I will treat briefly next issue on the morbid anatomy of enteric fever, also on the clinical and pathological aspects of dysentery as seen out here.

A. H. B. KIRKMAN.

THE FOLLOWING HAVE BEEN RECEIVED.—Clinical Journal (4), Hospital (4), St. Mary's Hospital Gazette, St. Bartholomew's Hospital Journal, Treatment, Climate, Polyclinic, Middlesex Hospital Journal, St. Thomas's Hospital Gazette, Medical Temperance Review, London Hospital Gazette, Broad Way, Therapist, Nurses' Journal.

Abdominal Injuries.

(Read before the Physical Society by Mr. Frank Cross, and received the Society's second premium.)

(*Continued.*)

Percussion.—If on percussion the abdomen is found to be tympanitic and liver dulness is obscured, rupture of the stomach may be suspected.

This symptom is often alluded to in ruptured intestine, but is seldom present in these cases, and from a diagnostic point of view is valueless, in fact, in five cases of ruptured intestine I have noted it is specially stated that "abdomen was rigid but not tympanitic."

Dulness in Flanks.—Dulness in the flanks is seldom met with in ruptured intestine as one of the early symptoms.

Should the patient survive with a ruptured intestine, the abdomen may be dull in one part and tympanitic in another, as the following case will show.

A man was admitted in 1897 under Mr. Golding-Bird, having been run over across the abdomen by a meat van. On admission, he was not much collapsed, but was suffering from the effects of alcohol. The anterior superior spine on left side of pelvis was found to be fractured. Patient was comfortable, and appeared to be going on well until 5 p.m. the next day, when his abdomen became distended and rigid; he complained of wind and general abdominal pains. He vomited frequently, the ejected matter having a fæcal odour, and his extremities became cold. Pulse 140, temperature 98·4°, respiration 30, mostly thoracic. At 2 a.m. on the second day he began to feel easier, and vomiting ceased. Pulse 108; no pain; abdomen less rigid. Towards evening he had more pain, complained of wind again, and abdominal wall became hard and distended. There was some dulness in both flanks extending well round to front of abdomen; the rest was tympanitic. The third day he felt better, but still complained of wind. The fourth day he remained in about the same condition, but abdomen became more distended and dulness increased. The fifth day he suddenly became worse at noon; abdomen much distended, dulness still increased, vomit almost fæcal. An enema was given as his bowels had not been opened since admission; this acted post-mortem. He died at 8 p.m. on the fifth day. The autopsy showed the intestine to be ruptured in several places, and the abdomen full of fæces, extending up under the diaphragm, which would account for the dulness.

Passage of Flatus and Fæces in Ruptured Intestine.—The passage of flatus with or without fæces should be noted, for, strange as it may seem, there are numerous cases on record of rupture of the intestine, both complete and incomplete, where the patient had passed flatus and had natural motions.

Ruptured Liver.—With rupture of the liver, besides the usual symptoms of severe abdominal injury, there will also be evidence of internal hæmorrhage, viz., the patient becomes blanched, the anæmia of lips and mucous membrane of the mouth being specially marked. There may be tenderness over hepatic area, and dulness in the loin, generally the right. Bleeding is not so profuse as might be expected, as the blood soon coagulates around seat of injury, thus arresting the hæmorrhage. The following case well illustrates this. In 1883, a boy, æt. 16, was run over by a cart, yet walked a quarter of a mile to Guy's. He had signs of collapse and was blanched. Was put to bed and kept quiet. He lived five days, apparently progressing favourably, when he suddenly died soon after straining to pass a motion.

The autopsy showed a fissure three inches deep in right lobe of liver, filled with blood-clot and covered with lymph. There was some slight local peritonitis around seat of injury.

In some cases of lacerated liver, sugar in the urine has been noticed.

Gall-Bladder.—Rupture of the gall-bladder is rare when that viscus is healthy. The accident is marked by extreme collapse and pain at seat of injury, but this is not constant, and diagnosis of this lesion is difficult. It is a very fatal injury, death in the majority of instances being due to peritonitis. The extravasated bile may become encysted, an abscess may form, and a biliary fistula result. The following is the only case out of 75 I have collected:—Patient was admitted under Mr. Lucas in June, 1895, for a fractured arm and scalp-wound, also injury to thorax and abdomen. On admission, his face was blanched and he was much collapsed. Pulse imperceptible. Respiration 46, thoracic and laboured. He died soon after admission. Post-mortem: humerus, olecranon and eighth to twelfth ribs on right side fractured. Ten ounces of blood and bile in abdomen. Gall-bladder was lacerated, spleen and right kidney ruptured. Lower lobe of left lung punctured.

Spleen.—The spleen is frequently injured, and there is no doubt that, unless the laceration is extensive, such cases are by no means always fatal, repair taking place, as in the liver, by blood-clot organising over the ruptured surface.

The following cases illustrate nature's attempt to cure:—A man was admitted under Mr. Howse in 1897, a cart having passed over his abdomen. Condition on admission, he was collapsed; temperature 98°; extremities cold: respiration 52, laboured; abdomen fairly flaccid; pulse 136, feeble. Next day at 2 a.m. his temperature rose to 104°, pulse became more feeble, and he died at 4.30 a.m. The autopsy showed the spleen to be extensively ruptured, all the upper third being pulped and almost separated from the main body. There was very little blood in peritoneal cavity. A mass of blood-clot covered the ruptured surface, and was firmly attached, completely controlling the hæmorrhage.

Again, in 1873, a girl aged five, was admitted into Guy's, having been run over. She was admitted for fractured jaw and injury to left side of thorax. There was no indication of any abdominal injury. On the

fourth day she was able to sit up, and appeared to be making good progress. Eight days after the accident she developed peritonitis and died on the twelfth day. Post-mortem.—The spleen was ruptured, but firmly surrounded by partly organised blood-clot. There was very little blood in the peritoneal cavity.

When death occurs it is generally due to hæmorrhage or peritonitis.

Ruptured spleen is considerably more common in malarial countries, where that organ is frequently enlarged by disease, and its substance softer and more easily lacerable. It is said that rupture of an enlarged spleen is less fatal than rupture of a normal viscus.

As to symptoms, there are none specially diagnostic of this injury, but the surgeon must be aided by noting the signs of internal hæmorrhage, position of blow, or fractured ribs over splenic area.

Kidney.—Although in my classification of frequencies of ruptured viscera the kidney was put third, being found ruptured in eight cases out of 75, I should point out that I have only taken into consideration those cases where the rupture was definitely demonstrated, either by operation or autopsy, but I have no hesitation in stating that it is an organ which is very frequently damaged, basing my assertion on the fact that hæmaturia has occurred in twenty-four cases out of seventy-five, in which it has been proved that bladder and urethra were uninjured. That lesion of the kidney is not commonly fatal may perhaps be accounted for by the capability it appears to possess of repairing mischief to its structure. Its anatomical position probably has much to do with the satisfactory termination in many of these cases, an injury to its structure not being necessarily associated with a laceration of the peritoneum; also the fact that the kidneys are double, no doubt possesses a strong influence in securing good results, for it has been proved that interference with the function of one will be compensated by the increased action of its fellow.

The most frequent causes of injuries to the kidneys are *crushing* accidents, as squeezing of body between buffers of railway trucks, or a cart wheel passing over abdomen, and there is no doubt that among other causes must be mentioned sudden strains, as in doubling up of the body, or in extreme lateral flexion; or again, in falling from a height on to one's feet. It is important to remember that the liability to become bruised from a given degree of injury, varies very widely in different persons. While the vessels of some will resist considerable violence, those of others give way under a comparatively slight touch, and soon show the discolouration of a bruise, and this, I think, is significant of the state of the structures generally; when the vessels of superficial parts are thus so easily ruptured, it indicates a fragility, or an unsoundness which in other regions may lead to disastrous consequences. Persons advanced in life, perhaps women more frequently than men, and above all, those with a preponderance of fat, are usually the subjects of this condition. We all know that with a man who "trains," the more he gets into condition, the firmer his flesh becomes, and with this the liability to bruising is very materially diminished. The importance of bearing this state of the tissues in mind, in diagnosis and prognosis is obvious.

The chief symptom of injury to the kidney is of course hæmaturia. This may follow almost immediately upon the injury, or not show itself for a day or two.

In 1894, a man was admitted under Mr. Lucas, a cart wheel having passed over abdomen at level of umbilicus. He was collapsed; pulse 130, weak; respiration 26; temperature 98; urine normal, but next day it contained a considerable amount of blood. He had pain in left loin shooting down to testicle. Hæmaturia ceased on the fifth day, and he was discharged cured on the twelfth.

In 1897, a man was admitted under Mr. Lucas, having been struck in left loin by the handle of a barrow. The next day he noticed blood in his urine, and when admitted his abdomen was rigid and breathing thoracic. There was pain and dulness over area of left kidney. Five days after, urine contained no blood, but some pus was present. Twelve days after accident, when rigidity had passed off, a swelling was noticed in left loin. Blood again appeared on one occasion two weeks after injury. He was discharged cured within three weeks of admission.

In 1897, a boy, æt. 3, was admitted under Mr. Golding-Bird, having been run over across abdomen. He was collapsed, and urine contained bright red blood. Next day urine was normal, and he was discharged eight days later, never having passed any more blood.

We must not forget, however, that serious lesion of the kidney may occur without giving rise to hæmaturia, the immediate cause is probably plugging of the renal vessels. Two cases in which this condition was found after death are related in Guy's Hospital Reports for 1868.

1895. A man was admitted under Mr. Lucas, having been crushed between the buffers of railway carriages. He was collapsed, conscious, extremities cold and moist. Pulse almost imperceptible. There was slight bruising of abdominal wall and back. He died the next day. Post-mortem showed left kidney and spleen ruptured. You will notice that there was no hæmaturia in this case.

How is such an injury to be diagnosed in the absence of this most reliable symptom? The earliest symptom in many cases may be pain over the renal area, shooting down to the testicle or thigh, with occasionally retraction of testicle. Mr. Lucas has also pointed out the following:—Firstly, there will be evidence of damage in one or other loin with symptoms of collapse and signs of hæmorrhage. The muscles are rigid and contracted over the space between ribs and os innominatum, and this region becomes rapidly dull on percussion. Secondly, one kidney having suddenly ceased to secrete, the urine if collected and measured will be found to be reduced to half the normal quantity, and this condition will be found to continue for several days should the patient survive.

(To be continued).

Obituary.

Samuel William Iles.

Enteric fever, which has robbed Guy's of so many distinguished sons in South Africa, has claimed a victim nearer home in the person of S. W. Iles, one of our most promising dental students.

Samuel William Iles was the only son of Mr. G. E. Iles, of Leeds, and was born in that city on May 10th, 1880. Educated at the Leeds Modern School, he passed the Preliminary Examination in Arts, with honours, at the age of fifteen. Subsequently he became the articled pupil of his uncle, Mr. Charles Rippon, L.D.S., of Dewsbury, and whilst thus engaged he mastered not only the details of mechanical dentistry, but also took out the usual courses in chemistry and chemical physics, and in addition became very proficient in shorthand, an acquirement which proved of much value later in the lecture theatre.

Entering Guy's in May, 1899, he at once made his mark, as one of *the* men of his year. All the junior appointments he held with conspicuous success, and whilst lying ill, he was awarded a certificate as "proxime accessit" for the first year's dental prize.

At Whitsuntide he went home to Leeds, where the annual meetings of the British Dental Association were being held; there he was seized with an attack of enteric to which he succumbed on July 8th. His bright and cheery companionship, together with his enthusiasm for and devotion to his work, rendered him popular with both his fellow students and the members of the staff.

"He has outsoared the shadow of our night."

Yet it is hard to realise that a young life of such promise is thus closed, and though

"From the contagion of the world's slow strain
"He is secure, and now can never mourn
"A heart grown cold, a head grown grey in vain"

we feel that Guy's has lost a worthy son, one on whom his school set great hopes, and whilst we tender our deep sympathy to his parents we share in their bereavement.

M. F. H.

Notice.

APPOINTMENTS, 1900–1901.

Assistant Demonstrators of Anatomy.—Messrs. E. H. B. Milsom, A. M. Webber.

Assistant Demonstrators of Chemistry.—Messrs. R. William Allen, H. F. Bell Walker.

Assistant Demonstrator of Biology.—Mr. A. B. O Brien.

Prosectors.—Messrs. H. H. Carter, J. H. Clatworthy, R. Felton, E. C. Peers, J. M. W. Pollard, C. H. Reinhold (first half), H. P Costobadie, B. Moiser, A. Leeming, M. G. Louisson, Richard P. Rowlands, G. Russell (second half).

Pass List.

University of Oxford.—June, 1900.

Final Examination for the Degrees of Bachelor of Medicine and Surgery.

R. C. Mullins.

Intermediate Examination in Medicine.

W. L. M. Day.

University of London, July, 1900.

INTERMEDIATE EXAMINATION IN MEDICINE.

Examination for Honours.

Anatomy (First Class).—R. P. Rowlands obtained Gold Medal.

Physiology and Histology (First Class).—P. R. Bolus obtained Gold Medal; E. H. B. Milsom; (Second Class), E. G. Goldie; (Third Class), N. I. Spriggs.

Organic Chemistry (Third Class).—P. R. Bolus, E. H. B. Milsom.

Materia Medica and Pharmaceutical Chemistry (First Class).—R. P. Rowlands; (Second Class), H. S. Brown.

PASS EXAMINATION.

Entire Examination (First Division).—J. Braithwaite; (Second Division), W. F. Box, F. W. Fawssett, L. S. H. Glanville, P. W. Hamond, R. Larkin, L. H. Moiser, F. C. Robinson, B. H. Wedd.

Excluding Physiology (First Division),—C. D. Pye-Smith, E. W. Strange; (Second Division), G. B. F. Churchill, H. M. Goldstein.

Physiology only (Second Division).—F. A Beattie, J. D. Bridger, J. Evans, D. S. Graves, G. S. Robertson.

Preliminary Scientific Examination, July, 1900.

EXAMINATION FOR HONOURS.

Chemistry (Second Class).—R. W. Allen.

PASS EXAMINATION.

Entire Examination (Second Division).—E. H. Adams, G. N. Bartlett, R. J. Pentley, G. Bellingham Smith, T. Turner, H. A. Watney.

Chemistry and Experimental Physics.—T. R. Cook, H. S. Knight, E. F. Milton, A. B. O'Brien, W. P. Purdom, F. A. Sharpe, J. T. Smalley, R. O. Williams.

Biology —T. H. Barton, G. Hamilton, E. M. Harrison, E. C. Lowe, P. D. F. Magowan.

Royal College of Physicians of London, July, 1900.

EXAMINATION FOR MEMBERSHIP (M.R.C.P.).—A. J. Cleveland, M.D. Lond.; T. D. Lister, M.D. Lond.

EXAMINATION FOR THE DIPLOMA IN PUBLIC HEALTH.—J. Harris, R. E. Williams.

Final Conjoint Examination, July, 1900.

MEDICINE AND SURGERY.—*R. M. Barron, *E. F. Reeve.

SURGERY AND MIDWIFERY.—F. G. Gibson.

MEDICINE ONLY.—*C. H. Brangwin, H. Braund, *J. M. Brydone, J. A. Butler, J. N. Dyson, C. W. Gibson, K. W. Goadby, *R. W. B. Hall, B. Instone, *W. B. Secretan, *T. P. Thomas, *E. J. Tongue.

SURGERY ONLY.—T. R. Beale Browne, P. W. L. Camps, F. G. Cross, E. T. Jensen, E. H. Kitchin, L. Pern, *A. Reid, R. Tilbury, F. D. Welch.

MIDWIFERY ONLY.—R. D. Attwood, A. E. Cawston, E. I. Davis.

* Denotes completion of examination.

First Conjoint Examination, July, 1900.

PART I.—CHEMISTRY AND PHYSICS.—H. Bacon, J. B. Ball, G. H. Cheyney, W. Byam, R. Edridge, H. M. Langdale, A. L. Morgan, O. S. Norton, J. E. Prentis.

PART II.—PRACTICAL PHARMACY.—H. V. Bagshawe, H. J. M. D. S. Barker, R. D. Bridger, G. Carlisle, T. T. Kelly, P. S. Mandy, J. E. Spiller, A. W. Talbot, J. L. Whatley.

PART III.—ELEMENTARY BIOLOGY.—R. Edridge, C. P. Harvey, M. Leckie, B. B. Metcalfe.

L.D.S. England Preliminary Science Examination, July, 1900.

H. E. Chinneck, H. S. Cranston.

Second Conjoint Examination, July, 1900.

P. C. V. Bent, R. E. Brayne, G. L. Buckeridge, F. W. Fawssett, C. F. Fraser, E. H. Griffin, F. P. Hughes, E. N. Jupp, W. W. Read, C. R. Shattock, H. D. Smart.

Victoria University.

FIRST PART OF FINAL M.B.

(PUBLIC HEALTH, THERAPEUTICS, AND MEDICAL JURISPRUDENCE.)

A. R. Thompson.

School Examinations—July, 1900.

ELEMENTARY ANATOMY.—A. R. Beaumont, H. P. Costobadie, G. H. Cheyney, C. J. Dismorr, C. P. Harvey, P. F. Minett, H. H. Jenkins, A. V. Maybury, W. Reeve, B. H. Stewart, H. D. Wyatt.

HISTOLOGY.—J. E. Spiller, 138; T. F. Wilson, 135; J. F. Rey, 134; H. P. Costobadie, 128; H. H. Jenkins, 117; F. H. Wallace, 115; R. P. Rowlands, 114; C. S. Morris, 112; M. J. Mottram, 110; W. Reeve, 110; A. E. F. Kynaston, 107; W. N. May, 103; G. C. F. Robinson, 103; C. H. Reinhold, 102; P. F. Minett, 101; W. T. P. Meade-King, 97; L. Myer, 97; J. A. C. Greene, 96; J. Cooke, 95; J. M. Barrionuevo, 92; W. S. Orton, 91; A. E. Rowlett, 91.

Birth.

SHARP.—On August 2nd, at 26, Bagdale, Whitby, the wife of Arthur J. Sharp, M.D., F.R.C.S., of a daughter.

Marriages.

EDWARDS—JACKSON.—On July 21st, at the Parish Church, Reigate, by the Rev. H. A. Gibson, M.A., uncle of the bride, Francis Henry Edwards, M.D., M.R.C.P., to Eleanor Margaret (Daisy), younger daughter of George Jackson, Cherchefelle, Reigate. At home the first three Wednesdays in October.

HALL—GEDDES.—On July 25th, at St. John's Church, Ryde, Isle of Wight, Edmund Stokes Hall, M.B. Lond., L.R.C.P., M.R.C.S., second son of John Selby Hall, of Stoneleigh, Ryde, to Jessie Alexandra, only daughter of Robert Geddes, of Trotton, St. John's Park, Ryde, Isle of Wight.

MOFFAT — HEATH. — On May 14th, at St. John's Church, Bulawayo, Henry Alford Moffat, F.R.C.S., of Bulawayo, to Ada, daughter of the late G. Heath, Esq., of O'obriep, Namaqualand.

PAYNE — DERRY.—On July 19th, at the Wesleyan Church, Streatham, Joseph Lewin Payne, L.R.C.P., M.R.C.S., L.D.S. Eng., of Devonshire Street, Portland Place, to Mary Castine Derry, youngest daughter of Charles J. D. Derry, of the Woodlands, Tooting Common.

STEWARD—GRAHAM.—On July 4th, at St. Agnes' Church, Moseley, by the Rev. W. H. Colemore, Francis James Steward, M.S., F.R.C.S., Assistant Surgeon to Guy's Hospital and to the Hospital for Sick Children, Great Ormond Street, to Edith Mary, younger daughter of the late Thomas J. Graham, of Edgbaston.

Death.

GIBB.—On January 27th, at Kingston, Jamaica, Robert Charles Gibb, M.R.C.S. Eng., L.S.A., æt. 49 years.

ED.—S. H.

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Calendar of Coming Events.

September, 1900.

Sat. 1.—Messrs. Lucas and Lane's take-in; Drs., J. A. Andrews and H. P. Wiltshire; Cl., T. P. Thomas.

Mon. 3.—Library re-opens.
First M.B. Durham Exam. begins.

Wed. 5.—Dental Test Exams. for Revision Classes begin.

Thur. 6—Messrs. Golding-Bird and Dunn's take-in; Drs., F. C. Wetherell and H. W. Brown; Cl., J. M. Brydone.

Sat. 8.—October Appointment List closed.
Hos.-Scho. C.C., Hanover, home.

Mon. 10.—Second M.B. Durham Exam. begins.
Names of Candidates for Entrance Scholarships to be sent to Medical School Office by this date.
Revision Classes for L.D.S. Eng. begin.

Tues. 11.—Application to the Medical School Office for Schedules for 1st and 2nd Conjoint Exams. to be made not later than this date.

Thur. 13.—Messrs. Jacobson and Fripp's take-in; Drs., C. Tessier and G. T. Collins; Cl., D. Forsyth.

Sat. 15.—Hos.-Scho. C.C., L.B.&S.C.R. Electric C.C., away.

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Some Points in the Treatment of Phthisis.

CLINICAL LECTURE BY DR. SHAW.

May 9th, 1900.

GENTLEMEN,—As at the moment I do not happen to have charge of any cases in the wards to which I can direct your attention, I propose to use this lecture hour in discussing with you some points in the treatment of a disease so common that its general features must be familiar to each one of you, however short is the time since you entered upon your ward appointments.

It is sometimes a matter of reproach to the teachers of clinical medicine, that so little time is devoted to the teaching of actual treatment of disease. No doubt the amount of time spent in the wards discussing the diagnosis and pathology of a case is usually considerably greater than that spent in describing the treatment adopted, or in indicating the principles underlying the choice of the various therapeutic measures.

This is, however, quite as it should be; for the period you spend in the wards of a hospital is only a period of preliminary study—preliminary, that is, to the long study of the practice of medicine which begins when you treat your first patient, and ends only when regretfully you retire from the active work of your profession. Properly regarding your work here as only a preliminary study, it is well that it should be chiefly devoted to those branches of knowledge which you cannot conveniently pursue after you have left the hospital, and that you should pay less attention to those of which you can daily add to your experience later on in private practice. The great difference between hospital and private practice is the existence in the former of a post-mortem room, and a constant crowd of earnest critics—the students. These two admirable institutions insure that diagnosis shall be founded on true data, and its accuracy determined in all fatal cases. While these advantages are with you in your clinical work at the hospital, it is well that you should be encouraged to study diagnosis and pathology, so that when deprived of them later on, as most of you will be in private practice, you may have a sure basis from which to observe the effect of treatment. The personal contact between the private practitioner and his patient, extending often over a whole lifetime, gives a better opportunity of estimating the results of your attempts at treatment than does the very complete though temporary observation afforded by a few weeks' residence in a hospital.

Do not think that I am making little of the importance of treatment. Treatment of disease is the function for which most of us exist, and, that being so, I am explaining why it is, nevertheless, not desirable that the greater part of

your time here should be spent in the study of therapeutics. I am trying to persuade the eminently practical man that he is not wasting his time at out-patients or in the wards because he has to listen so long to discussions on methods of diagnosis which seem to bore him, and has only occasional opportunities of joyfully adding to his long list of the names of diseases, against which are written for future reference prescriptions for their "cure." Although I propose to devote your attention essentially to treatment to-day, I shall not give such a man much opportunity for adding to his list, for of all the methods of classifying the treatment of a common disease, the least useful to the student is, I think, the enumeration in parallel columns of the prominent symptoms and complications in one line, and the therapeutic means of attacking each in the other. From the text-book point of view there is much to be said for this method, as it ensures completeness, avoids repetitions, and is easy of reference.

Another method of classification is time-honoured and useful, both when you have a patient before you and when the examiner has you before him. It is the division of treatment into *climatic*, *hygienic*, *dietetic* and *medicinal*. I shall have occasion to use this classification later on to-day, but in considering the treatment of phthisis I want you first to go to the root of the matter, and, recognizing the nature of the disease, grasp the great principles underlying our methods of attacking it. The advantage of this plan is that, when you have once worked it out for any particular disease, you can make use of it in a modified manner for diseases of an allied character; and when, as will, alas! only too frequently happen, you find your methods not crowned with success, you will be in a position to make a rational change in your therapeutics, and to estimate the likely value of any new remedy, according as it does or does not give promise of fulfilling one of the conditions you have laid down.

Before attempting any such investigation into the rational treatment of phthisis we must, then, have a clear idea of the nature of the disease. All of you can follow me when I say that phthisis is *due to the entrance into, and multiplication within, the lungs of a susceptible subject of tubercle bacilli, whereby changes take place in the pulmonary tissue which lead to its destruction, bacilli are diffused into other parts of the body, and a specific poison is manufactured and circulated in the blood.*

We believe that every symptom, complication and sequela of phthisis can be explained by one or other of the above processes, and a scientific treatment of the disease must be directed towards checking these processes as far as lies in our power.

As I shall now and then draw your attention to striking changes which have taken place in the orthodox treatment of phthisis in the last twenty years, and as these changes are chiefly due to alterations in our view of the essential nature of the disease, it is well that for comparison you should have before you a definition of phthisis, such as would have been found in the text-books of the earlier date. Here it is: "*A chronic destructive disease of the lung, resulting from repeated attacks of acute inflammation spreading to the pulmonary tissue, as the result of catarrh of the bronchi, set up by frequent exposure of a susceptible person to sudden changes of temperature and moisture.*"

To turn, however, to our modern description, let us take some of the points seriatim.

"*The entrance into.*"

As it is obvious that our patient cannot have phthisis until the bacilli have entered him, the consideration of this point leads us to deal with prevention rather than cure. Tubercle bacilli may enter the lungs in several ways. The most frequently denied way is the direct transmission of bacilli from parent to the unborn fœtus. Experiments on animals and clinical observation both made it likely that this does sometimes, though very rarely, occur. The only way in which one can imagine that such an entrance could be prevented would be by avoiding the existence of the fœtus, and there are some who believe that it would be for the benefit of the State that marriage should be rendered illegal for patients known to be consumptive. Such an interference with personal liberty for so very problematical an advantage to the community, hardly seems to be within the range of practical politics. Tubercle bacilli may also enter the lungs after birth either directly through the respiratory passages, or indirectly through the circulation from some pre-existing focus of disease. The former of these is essentially the common way in which phthisis is produced, and the prevention of such inhalation of bacilli resolves itself into (1) an attack upon the centres of manufacture, (2) an attack upon the means of distribution, (3) the removal of the person liable to be infected out of the sphere of influence.

The centres of manufacture of bacilli are human beings and animals affected with tuber-

culosis. To destroy the animals and isolate the human beings would be the most rational method of dealing with those centres. The destruction of tuberculous animals is already carried out compulsorily in some countries, and voluntarily to a certain extent in England, and must ultimately have a good effect in diminishing the supply of tubercle bacilli. But there are great objections to the isolation of human beings so affected. The difficulty of the detection of the disease, the enormous number of subjects, the comparatively vigorous health of many tuberculous persons, and the long period during which the disease lasts, make the problem of isolation a totally different one from that which confronts us, for example, with small-pox, scarlatina and the ordinary infectious fevers. It is analogous to the problem, which was solved in the Middle Ages, by the segregation of lepers, and is only entertained as a reasonable measure by some of the most advanced sanitarians. It is the duty of the medical profession to impress upon the public that there other more satisfactory ways of stamping out consumption than the isolation of consumptives, ways that have the advantage of not only preventing the particular disease, but of raising the health and well-being of the community generally.

It is upon the means of distribution that we should direct our attack. We must educate the consumptive patient as to the proper disposal of his sputa, by burning, disinfection or direct conveyance into the drains, we must urge upon sanitary authorities the importance of ruthlessly destroying all unhealthy properties, and impress upon the public generally that all dark holes and corners in their homes, to which no light or air can gain access, are in the highest degree dangerous. In this direction lies our best chance of preventing the existence of tubercle bacilli in sufficient number and in a sufficiently active state to carry on the disease to healthy individuals. Though I have said that the question of the entrance of bacilli into the lungs is rather a question of prevention than treatment of phthisis, it is important to remember that this is not entirely so. The same question must be carefully considered when one has to treat a patient already affected. Our attacks upon the bacilli already within him will be of little avail if a continual reinforcement by new bacilli is in progress. It must be remembered that the patient is himself a centre of manufacture of bacilli, and that unless care is taken the bacilli he expectorates may be inhaled, as well as those from other sources which constantly surround him.

The third point you will remember is the removal of the person whom we desire to protect from the sphere of influence of tubercle bacilli. This to be really effective entails his removal from the neighbourhood of all diseased persons and animals, and can only be carried out in a modified manner as a temporary measure in exceptional cases.

In fact, we must recognise that our attempts to prevent the inhalation of tubercle bacilli cannot possibly, under existing conditions of life, be entirely crowned with success. When all is said and done, as long as human enterprise demands congregation as an essential of life, and as long as tuberculosis as a disease exists, it will be impossible to prevent the inhalation of tubercle bacilli. Every one of us here has probably on many occasions inhaled large numbers, and for the explanation of the fact that we have not all phthisis, and for a more hopeful method of preventing consumption, we must turn to the next clause in our description of the disease.

"*The multiplication within the lung of a susceptible subject.*"

One of the most fundamental facts in bacteriology, as of agriculture, is, that for the cultivation of all kinds of organic life a suitable soil is essential. It is a most fortunate fact that the great majority of tubercle bacilli that are inhaled by human beings fall upon such unsuitable soil that no multiplication takes place. The individual peculiarity which makes certain persons capable of receiving and growing tubercle bacilli in their tissues, is called *susceptibility*. I must ask you to consider this matter carefully for a few moments, and first I should like you to notice that this question of susceptibility is raised in the ancient as well as the modern definition of the disease. Long before the existence of tubercle bacilli was suspected, physicians had noticed that the repeated attacks of catarrh which they believed to cause phthisis were much more likely to lead to this result in some people than in others, and they explained this by assuming that some only were susceptible. They believed that some inherited this susceptibility and others acquired it, and we must not allow the pride of our more accurate knowledge to cause us to neglect the valuable observations on these points made by our ancestors. In fact, although we are now in a position to more thoroughly understand the meaning of these observations, we have

been able to add little to the facts that had been laboriously collected in the pre-bacteriological days.

Inheritance, insanitary surroundings, privation, overcrowding, dissipation, alcoholism, overwork, absence of ventilation, acute and chronic illnesses were all fully recognised as predisposing causes of phthisis, and we do not alter these facts by merely changing our phraseology and saying that these things render the subject a suitable soil for the growth of tubercle bacilli. A great deal of most valuable work has been done in bacteriological laboratories which throws light on acquired susceptibility of animals. Certain species of animals which have, over and over again, proved refractory to inoculation with certain germs, are found to react or contract the disease, if previously starved, reduced to low temperatures, or fatigued by muscular exertions, or if, at the same time as a pure culture of the particular germ is inoculated, other bacteria are introduced into the body. These facts provide us with suggestions to explain the way in which human beings may be rendered susceptible to the attacks of tubercle. In the light of this additional knowledge we recognise that some of the predisposing causes recognised by our forefathers are due to the large numbers of bacilli surrounding the patient, and some to an acquired susceptibility, and we are thus able more effectually to deal with them. And we have to reckon with this question of susceptibility quite as much when treating an actual case of phthisis as when endeavouring to prevent the disease from arising. For whatever renders a patient, in the first instance, susceptible to the disease will render him susceptible to a recurrence, due either to a fresh inroad of bacilli, or to renewed activity of those already within him which have become temporarily quiescent. Hitherto we have spoken of susceptibility as a condition affecting the whole organism, but it is right that you should remember that there are reasons for believing that there is such a thing as local susceptibility of the pulmonary tissues. Laboratory experiments conclusively prove that where injections of active germs into healthy tissues may fail to produce any effect, a similar injection may result in rapid multiplication of organisms, if the tissue is previously damaged by traumatism or inflammation. Bronchitis, broncopneumonia and other so-called simple inflammatory conditions of the mucous membrane or alveoli of the lung, were regarded formerly as the cause of phthisis; they are, however, looked upon now as the causes of a local susceptibility of the lung to the growth of tubercle bacilli. It is in regard to this one point that, perhaps, the most striking change has taken place in the last twenty years in the actual treatment of phthisical patients. In former days the greatest stress was laid upon two factors in the cure of all consumptives—an "equable" climate out of doors, and avoidance of "draughts" indoors. It is difficult to estimate whether these two desiderata have gone out of fashion, because we no longer regard simple catarrhs of great importance in causing or increasing phthisis, or because we no longer believe that sudden changes of temperature are the essential cause of simple catarrh.

In each case of phthisis, then, we must seek out and remove, so far as we are able, anything tending to either local or general susceptibility, remembering that even inherited susceptibility can, to a certain extent, be counteracted by appropriate measures, and, *above all remembering that a man who has been once rendered susceptible by any cause is, during the remainder of his life, liable to be rendered again susceptible by exposure to the same or other cause.*

From the question of susceptibility we naturally pass to that of immunity. Experience with variola and diphtheria has raised high hopes that, for all diseases produced by a micro-organism, a substance may be found which, introduced into a human being, will render him permanently or temporarily immune to the disease, or even will arrest the activity of the germ after it has already begun to multiply. For the present one can only watch with interest and sympathy the laborious researches after a tuberculous antitoxin, and accept with caution the deductions which are drawn from experiments upon animals, as to the efficiency of the various substances introduced to our notice for the cure of human tuberculosis. At the same time, we must carefully remember that, unlike so many diseases, tuberculosis does not protect against itself, and that so far from a patient who has suffered and recovered, being immune, he remains as highly susceptible as ever.

"*Changes take place in the pulmonary tissue which lead to its destruction.*"

Hitherto we have been considering how we may prevent the tubercle bacilli from securing a point of vantage within the patient, or, if some have already done so, how we may prevent others from following suit.

We must now turn our attention to the treatment of the established disease. The tubercle bacilli have gained access to the lung, have multiplied, and are causing changes of a

destructive character in the pulmonary tissue. It is one of the every-day facts of the post-mortem room that this destructive change can be arrested. Healed phthisis is found in patients dying from independent disorders in varying proportions from 7 to 70 per cent., according to the class of patient and to the keenness of the observer. Probably the first essential in all such healing processes is the destruction of the tubercle bacilli, and in order to bring this about the greatest ingenuity has been exercised by physicians ever since phthisis was known to be a bacterial disease. The success of the surgeon in treating tuberculous affections accessible to the knife, and to the direct application of active antiseptics, encouraged the hope that similar attacks could be successfully made upon pulmonary lesions. But hitherto we have been baulked by the inaccessibility of the disease. Almost every agent known to be destructive of tubercle bacilli has at one time or another been largely employed, and attempts have been made to reach the focus of disease by many channels. Creosote, iodoform and guiacol have been administered by the mouth, sulphuretted hydrogen has been injected per rectum, carbolic acid and other germicides have been introduced into the circulation hypodermically, all sorts of volatile antiseptics have been used as inhalations, or mixed with oils and allowed to trickle down the trachea, and, lastly, various destructive agents have been injected straight into the lung through hollow needles penetrating the thoracic wall. Most of these measures have found favour for a time and then been gradually discarded. Some of them are still occasionally adopted by orthodox practitioners, or form the basis of treatment by quacks. It must not be assumed that attempts at destroying the bacilli in these ways will never be successful, but hitherto it has proved an insuperable difficulty to find a destructive agent which will destroy the germ without doing equal harm to the patient or his tissues. It cannot be denied that temporary benefit has followed the use of germicides in many cases, but whether by acting in this direct manner, or in some indirect way not at present understood, remains uncertain. But while we are unable to introduce into the system any reagent able to destroy the bacilli in appreciable quantity, the patient himself contains an army of agents capable of doing the work. It is in the process of phagocytosis that we must recognise the power for destruction of bacilli which precedes all cure of tuberculous lesions in the lung. You will learn full details of this most interesting phenomenon in your studies of general pathology and bacteriology. I have not time to do more than to remind you that it is a species of warfare between the micro-organisms and the patient's white blood corpuscles, in which the latter envelop and destroy the germ. Myriads of bacilli may be in this way got rid of, provided that the white blood corpuscles are in a fit condition to do battle. It is our duty to seek out what are the essential conditions for the corpuscles' success in the encounter, and to learn if there are any means within our power to produce these conditions if they do not already exist. Bacteriological researches indicate that there is yet another agent destructive to tubercle bacilli sometimes spontaneously developed within the pulmonary tissues. Micro-organisms of different species to tubercle bacilli, when rapidly developed in pulmonary cavities, seem to arrest the growth of tubercle. I believe it was, for a brief period in the history of our warfare against phthisis, contemplated as a reasonable proceeding to encourage the development of putrefactive organisms in order to deal destruction to the tubercle bacilli. I cannot refrain from a topical allusion and saying that any such proceeding would be as hazardous and unjustifiable as allowing the native races to assist us in our present war in South Africa.

If, then, in some way or other the bacilli have been destroyed, can we hope to exercise any influence in retarding the destructive processes that have commenced in the lung? From the post-mortem room we learn that the arrest of tuberculous lesions is invariably associated with fibrous changes in the tissue that has been actually affected, and with supplementary emphysema of the surrounding parts. Many years ago I remember Sir Samuel Wilks, in what I regarded at the time as a spirit of humour, suggesting that as drunkards got fibrous livers, and to cure consumption we wanted to get fibrous lungs, we ought to make all our phthisical patients drunkards. That others have regarded the suggestion seriously seems indicated by the fact that Osler warns us "that there is no evidence that the persistent use of alcohol promotes fibroid processes in the tuberculous areas." Except on the general principle that fibrosis is a natural process of healing, and that all natural healing processes occur most readily in conditions of good general health, we are at present unable to advance this salutary change.

Some drugs have an influence upon the bronchial mucous membrane, and by promoting

or arresting secretion by appropriate remedies one may hope to isolate the secondary inflammatory changes which spread from a phthisical centre, but which are themselves not strictly tuberculous. The complete shrinkage and absolute quiescence of a fibroid patch in the lung is generally associated with, if indeed it does not always require, a distended condition of the surrounding pulmonary alveoli. It seems likely that we can directly aid this process. Some believe that the success obtained by treatment of phthisis at high altitudes is partly due to the tendency to the production of emphysema in the rarefied atmosphere. Supplementary emphysema can probably be promoted by deep breathing exercises and pulmonary gymnastics, and if these are carried out vigorously at the proper stage of the disease great benefit may be obtained; perhaps, too, the cough which we must sometimes regard as a friend, sometimes as an enemy, may have a salutary effect in producing emphysema.

But we must remember that while we are endeavouring to promote this healing process in the lung the patient is liable to other dangers, whether the disease in the lung is progressing, standing still, or even retrogressing.

"*Tubercle bacilli are diffused into other parts of the body.*

This diffusion takes place by the blood-vessels, the lymphatics, or by the respiratory passages. With regard to diffusion by the two former channels we are practically helpless to stop it, except in so far as we can prevent the multiplication of bacilli. But we may enable our patient to diminish the risk of infecting the other parts of the body by bacilli carried through the respiratory tubes. Through the bronchi bacilli are either carried to other parts of the lung or into the mouth and thus into the alimentary canal. A careful adjustment of the force of the cough to the needs of removing the sputum may help us to diminish the risk of infecting other parts of the lung. To accede to the patient's request to soothe his cough so as not to allow it to disturb him at night, and for this purpose to prescribe strong opiates and other sedatives, will certainly increase the risk of sputum laden with bacilli stagnating in the tubes and infecting healthy alveoli. On the other hand, patients often cough far more than is required in order to remove the sputum, and the long-forced inspiration which precedes the cough may lead to bacilli being drawn into parts of the lung far removed from the site of disease. The danger to himself incurred in swallowing sputum should always be pointed out to a phthisical patient with no less emphasis than the danger he inflicts on others by carelessly scattering it abroad. The bacilli may find a suitable soil far down in the intestine, and the diarrhœa thus set up by tuberculous ulceration of the ileum will seriously handicap the treatment of the lungs. Sometimes, too, a patient entirely recovers from his phthisis, only to succumb later on to fatal intestinal obstruction. The fibrous healing in lung and bowel is perfect in both instances, but the healed ulcer of the intestine produces a stricture which leads to the patient's death.

"*A specific poison is manufactured and circulated in the blood.*"

To this toxin, as we now call it, many of the symptoms of phthisis are attributed. The fever, wasting, anæmia, night sweats and weakness are probably all due to it. We are anxiously awaiting an antidote to this poison, a tuberculous antitoxin. Meanwhile much can be done to lessen its effects. Pyrexia can be reduced by antipyretics, wasting by food, anæmia by hæmatinics, night sweats by belladonna, and weakness by general tonics. But none of these measures are truly curative; they are, in fact, the treatment of symptoms and not of the disease. Until we find our antidote, and probably long after, we must turn our attention to preventing the manufacture of the poison and not to neutralising it when it is made.

We are now in a position to tabulate the principles which should guide us in endeavouring to treat a case of phthisis in accordance with our present knowledge of the nature of the disease and the various means of combatting it at our disposal. We must—

1. Reduce to a minimum the number of fresh tubercle bacilli inhaled.

2. Reduce and keep reduced the patient's general susceptibility.

3. Reduce and keep reduced the local susceptibility of the pulmonary tissues.

4. Increase and keep increased the power of the patient's leucocytes to destroy tubercle bacilli.

5. Promote the rapid removal from the patient of tubercle bacilli, destroying such as can be got at during the process of removal, and all as soon as they are removed.

6. Encourage the development of supplementary emphysema.

7. Pending the discovery of an antitoxin, counteract as far as possible the effect of the poison by alleviating symptoms, such as wasting, sweating, pyrexia, etc.

8. Watch for, and treat when necessary, complications that may arise, such as hæmorrhage, pleurisy, secondary infections of other parts, etc.

Keeping these important objects before us we have now to consider how far we can effect them by measures classified under the headings: *climatic*, *hygienic*, *dietetic*, and *medicinal*.

Climatic.—In considering the question of climate, too much stress is often laid upon purity of atmosphere, as measured by the number of tubercle bacilli. This is a question of hygiene rather than climate, and we must confine our attention to climatic conditions, favouring (1) reduced susceptibility both general and local, (2) increased phagocytic power, and (3) production of supplementary emphysema.

As I have already indicated, the greatest difference of opinion obtains as to the importance of catarrhal conditions of the bronchi in producing local susceptibility to the growth of bacilli, and a still greater difference exists as to the influence of climate in producing catarrhal conditions. The tendency of modern times is in the direction of regarding catarrh as of less importance then formerly, and of considering exposure to cold and damp as less definitely the proven cause of catarrh. We are not, therefore, so interested in finding a climate which will prevent the occurrence of catarrh, as in finding one that will increase the phagocytic power. The best dogmatic statement that can be made about climate in the treatment of phthisis is as follows:—

That climate is the most suitable for a given consumptive patient which will encourage him to spend happily, and in exercise suited to his strength, the greatest number of hours each day in the open air.

Now, there are many things which drive a healthy man, and still more an invalid, indoors, or make him miserable if he stays out. Such conditions are: rain, high wind—either hot or cold,—dust, rapid changes of temperature, snow, fog, and scorching sun. These things should therefore be as little in evidence as possible in our ideal climate. But, of course, there is no ideal climate for all consumptives. The tastes and strength of the patient must be carefully taken into consideration. The patient who is too feeble to do much but sit about will not do this happily unless the temperature is high; and a temperature which makes sitting about pleasant will prevent the more active person from enjoying his favourite exercise, whatever that may be. No climate is suitable to the ardent golfer which is unsuitable to the cultivation of links, nor to the fisherman where no streams are to be found. In former days, when it was believed that different climates had some subtle and healing influence upon the lesions in the lung, the character and stage of the disease was scrutinised, and different places recommended for the bronchitic, or hæmorrhagic variety, and for the case in the first, second, or third stage of the disease. Now that we regard climate as an important means of bringing our patient into the highest state of vigour, and enabling his phagocytes to deal efficiently with the bacilli, we have regard rather to the patient himself, his powers and tastes, and send him to skate, or yacht, or camp out, or climb mountains, or stroll on the parade and listen to the music, or otherwise enjoy himself in whatever healthy manner seems most suitable to his condition. Formerly we made the climate fit the disease, now we endeavour to make it fit the patient.

Shortly after this view of the proper method of choosing a climate for our consumptive patient became established, the idea was promulgated that, if all one required was a climate that made possible and encouraged an out-of-door life, the climate did not matter at all so long as an out-of-door life could be insisted upon. The *vis a fronte* the pleasantness of the climate that drew a patient from the house the whole day long, could be replaced by a *vis a tergo*, the sternness of the physician who, having charge of the patient in an institution, could by strict laws and regulations drive him to the same course, and, by artfully-contrived wind-screens and sun-baths, could lessen the unpleasantness and increase the attraction of the outdoor life; and, at the same time, by organised excursions and amusements, could provide for each patient the particular exercise suitable to his condition. Moreover, it was contended that in an institution strictly governed by a master of hygiene, during the time that must necessarily be spent indoors the patient could be given almost as much pure air as when he was out of doors altogether. It is in accordance with views such as these that the so-called open-air sanatorium treatment of phthisis is based.

Established, first of all, in various places, the climates of which had obtained a reputation as being suitable for consumptive patients, these sanatoria are now springing up all over the world. They are doing a most valuable work, not so valuable, perhaps, in actually treating patients, many of whom could be equally well if not better treated elsewhere, but in educating patients and in educating the medical profession in rational methods of treating phthisis. In

fact, when I come, as I shall in a moment, to discuss hygienic and dietetic treatment, I shall have to point to measures adopted in these institutions as worthy of the closest imitation in whatever circumstances our patients may be placed.

But before leaving the question of climate I wish to point out that the marked success attained in these sanatoria, even in climates that at first sight leave much to be desired, should encourage us to hope for success even in cases for whom financial or social considerations make it impossible to seek a climate other than that in which they have acquired the disease. Even for the dweller in the London slums there is a chance, if the case come under observation early enough, and it is possible to carry out effectively other means of treatment. In fact, it cannot be too strongly impressed upon the public that the most perfect climate in the world is of no account whatever unless the patient can be well looked after. There is still among the laity a great tendency to send their consumptive relatives to distant climates without any regard to their means of livelihood when they get there. This is, no doubt, the result of the example set by the medical profession in a former generation. Medical men in such supposed El Dorados as South Africa, and Australia, can still tell us harrowing tales of patients in the last stage of consumption landed on their shores without means or friends, and totally unable to earn a living even if their strength permitted them to seek employment, which is as hard to find in those countries as in the crowded centres on this side of the globe.

Hitherto we have spoken of a climate as a temporary measure for the treatment of the disease, and, looked at in this light, our choice is often a large one, for many patients can for a short period afford to go great distances in search of health. But it will more often be your duty not to find for a patient a climate in which temporary residence may give prospect of a complete cure, but one in which permanent residence may give prospect of greatly prolonged life, or in which, cure having been effected, recurrence may be prevented.

Under the head of hygienic treatment of phthisis we might consider the questions of situation and construction of the house, its ventilation, the patient's occupation, clothing, exercise, recreation, &c., and you might be somewhat appalled by the prospect at this period of the lecture hour. But really the question of hygiene is a simple one. The laws of health are practically the same for a consumptive as for a healthy individual. They may sometimes with impunity be neglected by the healthy man, but never by the consumptive if he would get well and keep well. If I might criticise the modern hygienic treatment of phthisis, I would suggest that it is too much regarded as a temporary measure for the complete cure of the disease, and too little as a principle to guide the consumptive through the rest of his life; that it is tainted with the well-known fallacy that you cannot have too much of a good thing, and that too little attention is paid to the fact that the consumptive has a mind as well as a body. With these reservations we cannot do better than follow the example set by the authorities of the open-air sanatoria.

Let the consumptive live in a house sheltered from cold winds, and so placed as to receive a maximum of sun. Let his room be large and as perfectly ventilated as possible, avoid all dirt and dust, let him be warmly and lightly clad, occupy his mind and exercise his body—in fact, let him do nothing which will deteriorate his health, and leave undone nothing which will increase his vigour. These sound almost like platitudes, but as compared with the treatment of thirty years ago, when a patient was, so to speak, wrapped in cotton wool and put in a hothouse, they represent an immense advance in the treatment of phthisis.

There is one small point of hygiene which, valuable to every one, is perhaps especially so to the consumptive. Frequent complete expansion of the lung ensures thorough oxidation of the blood and increases general vigour. In phthisis it probably does more than this, and prevents unexpanded alveoli from affording a suitable soil for the growth of bacilli. Some physicians have therefore recommended that patients who are not in a fit condition to take such violent exercise as will call involuntarily for such expansion, should be encouraged to voluntarily overfill their chests at stated intervals during each day. In this way, too, the production of supplementary emphysema may be encouraged.

Under the head of diet I have not much to say to you. By diet we cannot hope to do more than counteract the wasting and promote the patient's general vigour. Nourishing food, and plenty of it, represent the main principle. To find the particular sort of food which will tempt your patient's appetite and agree with his often impaired digestion, will exercise all

your ingenuity. There are some who seem to think of food as of fresh air—that the consumptive cannot have too much of a good thing, and they recommend that if appetite fails it should be replaced by the stomach pump. But as it is better that your patient should be attracted out of doors by his favorite exercise in a pleasant climate, so will his food do him more good if he eats it with appetite than if it is forced upon him. It is true that forced feeding will increase the patient's weight, but it is open to doubt whether unused fat deposited in the connective tissues is of any value to the invalid, except from its effect upon his mind.

And this leads me to impress upon you a very important factor in the treatment of phthisis by any method. I have spoken of ensuring the patient's happiness in whatever climate you may place him. It is essential to his happiness that he should believe that the measures you are recommending for his treatment are likely to be crowned with success. You might imagine that, *spes phthisica*, the hopefulness of recovery which is said to be so prominent a feature in consumptive patients, would make it unnecessary for you to take trouble to cultivate this belief. Personally I am much more familiar with a morbid apprehension in phthisis, due, no doubt, to the great publicity now given to all matters of health and disease. To overcome this, and to encourage a confident belief in the efficacy of your treatment, it may often be desirable to allow your patient to undertake more elaborate measures than you regard as absolutely necessary, for it is as true now as in the days of Naaman, that the simpler the nature of a treatment the less it is held in regard by the patient.

It is, no doubt, to a certain extent this feature of the open-air sanatorium treatment which renders these institutions so attractive. The patient feels that a great deal is being done for him, that every wheel in the elaborate machinery is working towards his cure. If I have spoken somewhat slightingly of the value of these institutions, it is because I want you to remember that the treatment of phthisis cannot be embraced in the simple phrase, "Send the patient to an open-air sanatorium." For certain classes of patients it is impossible to devise any better plan. For the poor who are unable to provide themselves with decent sanitation or good food, for those in better circumstances who cannot be trusted to carry out instructions without constant supervision, for those who have all their lives neglected the laws of health, and require a systematic practical education in the elements of hygiene—for these nothing can equal a temporary residence in a sanatorium. These sanatoria should rightly be regarded as places of education rather than places of cure, for there is no more important fact to be remembered in the treatment of phthisis than that the improved vigour of the patient which, brought about by climate, hygiene and diet, enables the progress of the disease to be arrested, must be efficiently maintained by the same measures if we are to avoid a recrudescence of the mischief.

I have left but little time to speak about medicinal treatment. I have already indicated the numerous germicides that have been given in every conceivable way, and have told you why at present we have failed to get any striking measure of success by their use. These attempts to directly destroy tubercle bacilli should not be persevered in if they interfere with digestion or impair the patient's appetite, but some patients bear them well and seem to improve under their use.

Various medicines may be used to render the bronchial secretion more easy of expectoration, to lessen its quantity, or to allay a harassing cough. But general tonics still remain the favourite drugs. Iron, arsenic, quinine, strychnine and the hypophosphites may all in turn be tried, and undoubtedly have a good effect in increasing the patient's phagocytic power.

So whichever pathway we tread, climatic, hygienic, dietetic, or medicinal, we reach the same goal. Place the patient in the highest state of physical fitness and his natural tendency to combat the disease will assert itself. Surely the moral of this is: *recognise the disease early*, and I will end this lecture on treatment by urging you to devote yourselves to the study of the means of diagnosing phthisis in its earliest stages, for thus and thus only may you anticipate very considerable success in putting into practice the principles to which I have directed your attention to-day.

Papers by Guy's Men.

A Clinical Lecture on Hæmaturia. By J. H. Bryant, M.D., M.R.C.P. Lond.—*Clinical Journal*, 25th July.

WE notice with pleasure that Messrs. Down Bros. have received the highest award, the *Grand Prix*, in Class 16 (Medicine and Surgery), Paris Exhibition, for their exhibit of Surgical Instruments and Aseptic Hospital Furniture. The fact that the Jury of Awards was international and composed of medical men will show the real value of such a recognition as this.

Abdominal Injuries.

(Read before the Physical Society by Mr. FRANK CROSS, and received the Society's second premium.)

(*Concluded.*)

Should hæmaturia follow an injury over region of right kidney, a less favourable prognosis should be given when we consider the close proximity of the liver to that organ, and the possibility of damage to such an easily lacerable viscus.

Bruising of the kidney, resulting in extravasation of blood into its substance and under its capsule, may occur without rupture of its capsule, and when accompanied by much perinephric hæmorrhage may present symptoms of ruptured kidney.

In injuries to the kidney, unless the symptoms such as extreme hæmorrhage are urgent, records of cases show that there is ample time for a thorough investigation of the individual case before deciding on operative measures.

1896. Patient admitted under Mr. Davies-Colley, the wheel of a cart having passed over his abdomen. He was collapsed; temperature 96·6°; pulse weak; urine contained blood. Except for some pus in urine patient improved daily for ten weeks, when he became worse, abdomen was opened and a large perinephric abscess was found, this was drained and patient went out fourteen weeks after admission.

A rupture of the peritoneum is an extremely rare complication in such injuries when the kidney is healthy.

Recurrent hæmaturia is no doubt caused by blocking of the pelvis or ureter with blood-clots. In some cases where this is a symptom you will find the blood-clots passed are tubular in shape having no doubt been moulded in the ureter.

Boy, æt. 5½ years, admitted in 1898 under Mr. Davies-Colley. Eight days before admission he fell, striking his right side against the curb. Blood was noticed in his urine on the eighth day, and patient was brought to Guy's. On the second day after admission there was no blood in the urine, it was present on the third and fourth days and absent on fifth and sixth, after which it was found to be increasing in quantity and patient was becoming anæmic and weak. A tumour could be felt in right loin. On the ninth day after admission patient was operated upon. Right kidney was exposed, it was pale, and pelvis distended; on being opened it was found to be full of blood-clot. Patient was discharged cured.

Bladder. *Rupture of the bladder* is rare. It is very fatal, and must be diagnosed early to give any hope of successful treatment. The patient constantly expresses a desire to micturate, but will at the most only be able to pass a few drops of blood, or blood and urine. On passing a cathether, only a small quantity of blood and urine will come away. If when the catheter is in the bladder it is slowly turned it will often suddenly slip further in, having passed through the rent in the bladder wall. The rupture may be either intra- or extra-peritoneal. In the former, peritonitis will probably set in about the third day, while in the latter several days may elapse before symptoms of suppurative cellulitis supervene.

Peritonitis.—Peritonitis, without lesion of any viscus, undoubtedly often follows a severe blow upon the abdomen. This is evidenced by severe pain over the injured part, fever and constitutional disturbance, varying according to the amount of inflammation. The following case is only an example of many, the symptoms of which I think may well be ascribed to this cause.

In 1896, a man was admitted under Mr. Howse, having fallen and struck his abdomen against the corner of a table, four days previously. On admission, he was pale, eyes were sunken, breathing thoracic, abdomen rigid, and he complained of great pain. For ten days his temperature varied between 98° and 102°, after which he began to recover and went out one month after the accident.

Ruptured peritoneum.—That the peritoneum can be severely injured and even ruptured, without injury to any of the viscera, the following case well proves.

In 1897, a man was admitted under Mr. Golding-Bird having been run over across the abdomen by a four-wheeled cab. He was collapsed; pulse could not be felt; respiration shallow and thoracic. Patient died twenty minutes after admission. Autopsy showed hæmorrhage into peritoneal cavity, there being a large rent in peritoneum just above right kidney. The main vessels were uninjured, neither was any viscus injured.

Pupil.—With regard to the pupil as a factor in the diagnosis of abdominal injuries, not much can be stated. There is no doubt, however, that internal hæmorrhage is attended by dilated pupils. The following case illustrates this.

A man was admitted under Mr. Lucas in 1899, having been crushed between buffers. He was very collapsed, in great pain, which was not localised to any special part of abdomen. He was blanched, extremities cold and moist; pupils widely dilated; pulse 120, weak; respiration shallow and entirely thoracic; abdomen rigid and resonant. Mr. Lane opened abdomen and found left lobe of liver extensively ruptured.

It has also been stated that in injury to the intestine the pupil corresponding to the side of the body injured contracts. This condition has never come under my personal notice, neither have I found it noted in any of the cases I have investigated.

With reference to the *treatment* of abdominal injuries, time will not allow of my discussing, even briefly, either the dieting or the administration of drugs, both of which you will find exhaustively dealt with in text-books, neither shall I enter into the methods to be adopted in those cases which necessitates operation, as when once the diagnosis is made, the procedure is generally obvious enough. But what I do wish to insist upon is the necessity for *absolute rest*, to be maintained at all costs directly after the

accident has occurred. In no example, however apparently trivial, should it be neglected, for as Mr. Bryant has remarked, "If the mischief is but little, that little will be more materially repaired, if much, its evils and its consequences will be materially modified By such a practice the surgeon, it is true, may at times make much of a slight injury, but a few days' rest will be the only harm done, whilst on the other hand, by adopting the practice recommended he will guard against the opposite irremediable error."

Specimens in our own museum will indicate how nature will do her best to cure such injuries as laceration of liver, spleen, etc., if we, by exercising a certain amount of care, will only allow her the chance. The following case will also, I think, help us to bear this important fact in mind.

In 1861, a man was admitted under the care of Mr. Hilton. The report states that he was a very large fat man. On day of admission a roll of lead fell on his chest and right side. He was much collapsed, pulse feeble, and it was thought that he could live but a few hours, but he got somewhat better, only to expire, however, nine days after the accident.

Autopsy showed all the organs to be healthy except the liver, which was found to have the diaphragm closely adherent to its upper surface; this being separated, a long vertical fissure was seen passing from back to front of organ across right lobe, it was one and a half inches deep. The diaphragm did not cover the liver right up to the edge, and the part of fissure that remained uncovered was already closed by blood and lymph, in fact undergoing repair, all hæmorrhage being stopped.

The following case, I think you will agree with me, is interesting, as showing how a wound of the intestine was closed by adhesions. It is reported in the *Lancet*, 1853, by G. T. Guthrie, P.R.C.S., Sergeant Matthews, of 28th Regiment, was wounded at Waterloo, by a musket ball about one inch below umbilicus. He walked to a village in the rear, where he remained for three days. Guthrie says: "My attention was particularly attracted to him in consequence of his having passed the ball per anum six days after receiving the wound." The external wound healed, and he marched to Paris to join his regiment. He often had attacks of pain in the bowels in situation of wound. On attempting one day to pass a motion, he found, after many efforts, that something was blocking the anus, and on taking hold of it and drawing it out, he found that it was a portion of the waistband of his breeches, including a part of the button-hole—a fact verified by Staff-Surgeon Dease who wrote an account of this peculiar case. After this the man had no further pain, except after a copious meal, which was probably due to adhesions.

The chief indications for operative treatment are afforded by the presence of profound and prolonged shock. The *duration* of shock is of greater importance than its *intensity*. It is difficult at first to distinguish the syncope produced by hæmorrhage from the shock caused by ruptured intestine. In the early period we shall have to arrive at a diagnosis from the nature and violence of the injury and the general condition of the patient. When peritonitis is declared an exploratory operation is urgently indicated, as collapse comes on very quickly, and a few hours' delay may negative all prospect of recovery. Exploratory laparotomy, in the present days of aseptic surgery, has no very serious inconvenience, and should be practised in those cases where ruptured intestine is suspected. At a later period we have not only the ruptured intestine to deal with, but a septic peritonitis, which produces a most profound depression, and often necessitates an undue curtailment of some essential step in the operation, or occasions death of the patient before completion.

The following case is an example of good results obtainable by early operation:—A man, aged 30, was admitted under Mr. Lucas in 1899, the pole of a van having pinned him against the wall. On admission, his knees were flexed, he was collapsed, conscious, and complained of great pain in region of umbilicus; pulse 100, almost imperceptible; respiration 20, thoracic; temperature 96·8; abdominal wall rigid, retracted and resonant. There was a reddish bruise just to left of umbilicus. His pupils were contracted. Mr. Lucas saw patient soon after admission, diagnosed ruptured intestine, and performed laparotomy without delay. On opening abdomen about one pint of darkish blood came out; two and a half inches of transverse colon was found bruised and divested of peritoneum, the jagged ends of which were stitched over the gut. The small intestine was found completely severed, as by a clean cut, just below duodenum. This was joined by a Murphy's button, the abdominal cavity washed out with warm water, and the abdomen sewn up. Patient made an uninterrupted recovery without any undue elevation of temperature. The button was passed on the nineteenth day, and he was discharged perfectly cured in sixty-five days from date of accident.

When severe injury to the kidney is suspected, and it is found that hæmorrhage is not controlled by means of administration of drugs, such as ergot, and the local applications of ice bags etc., the kidney should be exposed before the patient is too much weakened by hæmorrhage, or septic phenomena have developed.

Dangerous symptoms which may develop are, septicæmia and cystitis, with extension of inflammation through the bladder to the opposite kidney, these must be dealt with accordingly.

And now, gentlemen, before I conclude this, I fear, sadly inadequate paper, I should wish to acknowledge the very material help I have obtained from the many published papers of Mr. Poland, Mr. Bryant and Mr. Lucas. I fear that in the limited time at my disposal I have but sketched out roughly the lines on which this subject should be treated.

My object will, however, be quite fulfilled if it only serves as some small guide to any of my colleagues who may be brought face to face with these extremely difficult cases.

In the discussion that followed Dr. Beddard suggested that a diagnosis of internal hæmorrhage would be aided by taking the specific gravity of the patient's blood. The procedure being so simple, there is no reason why it should not be carried out as a routine practice in all cases of doubt.

Xylol and chloroform are mixed in sufficient proportion to obtain a sp. gr. of 1060. A drop of blood from the patient is then blown in from a pipette, and either xylol or chloroform added until the drop neither sinks nor swims; the sp. gr. is again taken, and this in cases of anything like profuse hæmorrhage would be considerably reduced.

Guy's Hospital Missionary Society.

ON Wednesday, July 11th, a meeting of the Guy's Hospital Missionary Society took place in the Board-room. The gathering was one of unusual interest from the fact that two of our nursing staff, Nurses Custance and Frankham, who hope to leave shortly for the mission field, were to have presentations made to them by the society.

Nurse Custance, who has already had experience in African work, and who expects, on going out again, to take up work in Zululand, was the recipient of a nursing-bag containing the most necessary requisites; and Nurse Frankham, who is going out under the Universities' Mission to Central Africa, was presented with a midwifery bag.

In the unavoidable absence of Mr. C. J. Symonds, Dr. Spriggs took the chair. In his opening remarks the Chairman alluded to the satisfactory number of those who had gone out from Guy's to the foreign field, and congratulated the society upon the fact that two more were now added to their number. He added that a great interest would be always taken by the society in their work.

Nurse Custance was then given her presentation. Nurse Frankham was unable to attend because of her examination, and in her absence the Rev. B. Sladen read a letter from her, in which she expressed regret at her absence, and thanked the society for her gift. Mr. Sladen then replied for Nurse Custance.

The Rev. Duncan Travers, Secretary of the Universities' Mission to Central Africa, was then called upon for his address. He first described the basis upon which the society works, mentioning that the workers, of whom they had about 109, 15 of whom were nurses, received no remuneration from a worldly point of view beyond mere necessities. This, he said, was an advantage in some respects, since it kept from amongst them those who were not whole-hearted in the Master's service. He further said that it was well known amongst those leaving for the mission that they might be giving not only their services, but their lives for their Lord.

Mr. Travers then read extracts from a letter from Dr. Howard, an old Guy's man, who is now doing very good work in the mission. Dr. Howard wrote that he had just been on a vaccinating tour, and within three months had treated as many as 1,000 cases. Dr. Howard stated that he was just about to leave on a similar tour, and hoped that more nurses were coming out, as there was a great need for them.

Mr. Travers then addressed any that might be going out, and told them not to expect or try to make the natives English in their habits, but rather to adapt themselves as far as possible to their customs. He also emphasised the fact that while employing their medical knowledge to supply the need of the bodies of the natives, it was necessary at the same time to care for the primary need of their souls, and thus fulfil the noblest and highest calling in giving to them the knowledge of their Saviour.

Dr. Spriggs then thanked Mr. Travers for his address, and also for reading to them the extracts from Dr. Howard's letter, of whom they were always pleased to hear. He further said that Dr. Howard was a student with him at Guy's, and was always held in the highest esteem by his fellow-students. The meeting then closed with the Benediction.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

More Trouble.

Externs' Room, Guy's Hospital.

SIR,—Several of the members of the August Externs having been put to considerable inconvenience, and the hospital to some expense, owing to the frequent mistakes occurring in the map of the Guy's district published by your GAZETTE, and sold at the excessive charge of sixpence, we feel compelled to draw your attention to these facts, and to request you to publish a new map with the amended boundary marked correctly, and the street names, as recently revised, properly inserted.

We also request that you will impress upon the authorities the desirability of keeping such a corrected map by them when they issue the "lying-in" cards, in order that cards may only be issued to those residing within the boundary.—Yours faithfully,

THE AUGUST EXTERNS.

Wednesday, 29th August.

Prizes.

THE Gaskell Gold Medal and Prize at the recent Examination held by the Medico-Psychological Association of Great Britain and Ireland was awarded to Dr. Maurice Craig, of Bethlem Hospital.

Passim.

WE have been so frequently assured by the morning press that the end of the Boer war is in sight, that a repetition of the same piece of news now elicits only the most feeble show of interest. But lately we have had additional evidence of the alleged collapse in the presence of some of those who went out from Guy's to the front. Messrs. Ayre-Smith, Brailey, Osburn, and Wrench have returned, looking very fit and khakhi, and with stories worth the telling, if only the right train of thought can be induced and the curious reticence of the man who has seen something out of the common run of things overcome by judicious questions. Ideals have been shattered and the poetry has in many cases turned out to be but sorry prose, but in those six months in the field they have seen the real life without the cheap draperies of petty civilities, and they are incomparably the richer for the experience. Few would go through that time again, but none would have missed its priceless experience.

BY the relief of Peh-Ching—we have it on the very highest authority that this is the only genuine spelling—the natural anxiety which was felt at Guy's for our representative, Dr. Wordsworth Poole, has been allayed. Even when the rumours were most ominous, those who knew him found it hard to imagine that a Chinese mob, however numerous and well armed, would prove too much for the African explorer. His natural resources and unfailing pluck gave colour to the hope that even if the whole foreign settlement were overrun by Celestial ruffians, he at any rate would manage to scrape through to safety. But fortunately the test never came, and fortunate it is, for Dr. Wordsworth Poole is far too good a man to go out on the spear of a yellow-skinned boxer.

WE have as yet refrained from any allusion to the hospital question in South Africa, mainly because in the din of the many brazen voices speaking with Authority we feared that our own modest little twitter would be lost like a straw in a whirlpool, and also because our correspondent at the front, who speaks of what he sees without fear of man, has given in his letters a faithful picture of military hospitals from the commencement of the war, so that anyone of average intelligence can form a correct estimation of things as they are. A letter which appeared last Saturday in the *Spectator* forces us with reluctance to break silence, both because it appears over the signature of a present Guy's man and because it contains statements which are likely to have a perfectly fictitious value attached to them by irresponsible persons and papers.

THE writer of this letter, with commendable honesty, prefaces his remarks by a statement of the grounds on which he claims competence as a critic. "Having just returned from South Africa after an attack of enteric fever, and having had some experience of the hospitals out there, I should be pleased if you can find space for this letter . . . I have been through a six months' course of medicine and surgical dressing at one of the largest London hospitals. I was also a patient in a London hospital for three months, and . . . . it gave me an insight into the workings of a hospital which served as a basis of comparison." Speaking from particular knowledge, the writer was a surgical ward clerk for three months and a medical ward clerk for a like period. Before the completion of this appointment, however, he fell ill and was warded in Clinical, as he says, for three months. On gaining convalescence he went for a year's holiday in Australia, and on his return volunteered for service in South Africa. There, unfortunately, he again fell ill and was invalided home. So much for the preamble. Unlike many amateur reformers, our own particular friend does not voice any objections to the quantity, quality and distribution of medical stores. He dismisses this part of the controversy with the remark, "I believe what was done was the best possible."

BUT in the light of his superior knowledge he at once proceeds with an attack on the R.A.M.C. and the Nursing Department. What he found lacking was medical knowledge. "I don't refer to the many civilian doctors and dressers, who displayed skill and energy of the highest order. But there is no doubt that, with the necessary exceptions to the rule, the R.A.M.C. as a whole are not nearly as competent as they might be." The explanation of this sweeping statement he finds in the method by which the officers of this Royal Corps are appointed. "A young man qualifies, holds perhaps a house appointment at some hospital, passes the army medical examination, undergoes a year's special training at Netley, and is

then practically settled for life." If we omit the year's special training, the newly-fledged surgeon-lieutenant bears a striking resemblance, both in origin and professional experience, to the civilian medical officer, of whose skill too much cannot be said. This at any rate must be the deduction drawn from an inspection of the names of the men who left Guy's in this capacity. And yet "the consequence of all this is that one constantly came across cases in which the doctor of the R.A.M.C. was unable to reduce a dislocation or set a fracture by the proper methods, and it was often necessary for the civilian to step in and perform the operation successfully."

THUS we have it, on the authority of a surgical ward-clerk that the officers of the R.A.M.C. as a body are ignorant of elementary surgery. But this criticism is not so surprising when it is viewed in the proper light, for we must all have met the ward-clerk with inherent genius unrecognised by soulless registrars, whose surgical knowledge shamed the dresser, and caused the house-surgeon to taste the bitter fruits of jealousy. We have all met him, and later some of us have seen him vainly struggling against the fetters of crass ignorance which shackle the Colleges. And we have seen him fighting his unequal fight again, and again, with intervals of six months. Leaving the medical department smarting under the lash of his criticism, the writer next proceeds to demolish the paper castles which have been raised to testify the excellence of the nursing arrangements.

"THE same remarks apply to the Nurses." One sweep of his pen and everything topples over. Here he speaks with the experience of an educated patient who has known both systems. While warded in Guy's where the ratio of nurses to patients is perhaps one to five or less, where in addition all the surgical dressings, and some of the borderline duties are in the hands of students, where the resources are unlimited and the internal economy the finished product of two hundred years, he made unto himself a measure by which to judge the shortcomings of a military hospital, 8,000 miles from its base, and subject to all the strains and congestions of active warfare. And what does he find? That the medical orderlies apply fomentations and minor dressings, and that the Sisters do not actually nurse but only supervise. That temperatures are "faked" by the patients and that ravenous typhoid-patients shake down the thermometers to normal in order to get a little bread and butter. "There were of course many very serious and even fatal results of this trickery." Would that this critic could have had but two more months' experience, at, say, the South-Eastern Fever Hospital where they commence solid diet in typhoid cases when the patient is well enough to ask for it!

AND now, before we dismiss this subject, we should like to offer a word of thanks to the writer. In no part of his letter, which is published in extenso, does he mention the hospital at which he received his six months' training. We are often the scape-goat of the lesser journalism; let us be thankful that our name is not dragged into the controversy which must follow the publication of this letter in so important a paper as the *Spectator*.

IT has been customary in former years for the winter session to open with what might be termed a "combined display" by the Physical Society and the Students' Club. This year, for the first time, will see a new order of things. On Monday, October the 1st, Dr. Hale White will preside at the opening dinner of the Club in the College; on the Saturday following the first meeting of the Physical Society will be held. With regard to the dinner, it is of primary importance that early application for tickets should be made to the hon. secretary of the Students' Club, in order that the necessary accommodation may be ensured. We have none too many occasions for reunion of the Past and Present, and this dinner promises to be a happy meeting of old, new, and future Guy's men. Therefore should application for tickets be made in good time, lest procrastination lead to disappointment.

THE old, familiar colonnade steps on which generations of men have waited for their physicians, will soon be altered beyond recognition. As a final step in the repair of the surgical wards, the landing between Lydia and Martha wards has been demolished, and an iron and cement fire-proof floor is rapidly replacing the worm-eaten timbers and floor-boards which have slept undisturbed through a couple of centuries. This entails the removal of the funny old wooden doors which guarded the southern entrance to Guy's House. As the work of destruction proceeds, much that is of interest to the engineering archæologist is brought to light. There are wrought-iron nails,

shaped very much like the modern "cut" nails, but measuring eight and ten inches in length, huge iron ties with square bolts and threads that follow no known guage, and any quantity of massive timbers, some worm-eaten, others as sound as when first put in.

The new work will consist of brick arches on brick piers, and will be quite in harmony with the rest of the building. The balconies which have been erected outside Patience, Charity and Lydia have proved an immense boon to the patients, and are now being followed by similar constructions on the other block, and now that the stonework of the Front Surgery extension is completed, the balconies for Lazarus and Naaman will be commenced. Again, it is expected that in a month's time the new laundry will commence work, and this will be followed by the electric lighting system passing into hospital control. That will mean that the wards which have been wired for, but have not yet received the current, will be electrically lit; and lastly, it will indicate that the shaft in the surgical buildings will receive its elevator, and that the old hydraulic contrivance on the medical side will give place to a more economical and less erratic electric lift. So the old order changeth.

Men who are reading for October examinations are beginning to find the summer vacation somewhat troublesome. While the librarian is away on his well-earned holiday, the hospital library is of course closed. This in itself would not prove of very great inconvenience were it not for the simultaneous closing of the dining hall in the college and the transference of the whole of the impedimenta, including the "college dinner," to the reading-room. So the reading man who does not live in college has to make himself as comfortable as he can in one of the museums, unless he risks the distracting delights of the park. It seems a singularly inopportune time to choose for the redecoration of the dining-hall; we therefore take this opportunity of calling the attention of the committee to the subject.

By reference to the correspondence column in this issue it will be seen that the Extern Obstetric Assistants for the month of August—styling themselves the "august Externs"—have broken out in a fresh place. Little is expected of, and much is conceded to, these hard-worked and sadly neglected officers of the hospital. Their quarters are notoriously uncomfortable, they rarely know an unbroken night's rest, and are even forbidden the certainty of a peaceful hour at dinner. And now they have discovered that the "map of the district," which is in itself a marvel of cheapness and topographical skill, errs in one or two minor details, and this has still further depressed them. Be of good cheer, ye externs! Remember that the appointment you are now filling is the finest that the hospital can offer, and rest assured that you will look back on August, 1900, as the happiest month in your lives. Congratulate yourselves that a benign Gazette has given you a map at all with which to work. Think how much worse matters might be had it been a time-table. With reference to the last paragraph in the letter, we absolutely decline to quarrel with the authorities on the august externs' behalf.

Numerous complaints, as yet, however, merely verbal, are pouring in with reference to the condition of the Clinical Laboratory. Habitués of this cheerful retreat allege that they cannot find anything there but rubbish. As far as we remember, the reason is simple. There is nothing but rubbish there to be found. However, if some bold man will pluck up sufficient courage to voice his grievances in the Gazette—well, perhaps, we shall see.

Obituary.

Henry Newcombe Clarke.

Died August 14th, 1900. Aged 27 years.

It is with the deepest regret that we have to record the death of H. N. Clarke. Always a very keen sportsman, Mr. Clarke will be remembered for the very material and wholehearted manner in which he supported the athletic clubs at this hospital. When at Dulwich he showed more than ordinary skill at "three-quarter," and in his last year captained the school fifteen. Going up to Caius College, Cambridge, in 1892, he soon found a place in the fifteen, and although never a blue, yet his football record was particularly good. Graduating B.A., in 1895, he came up to Guy's, and at once proved a very valuable addition to the team, as well as a constant member of the Surrey County Fifteen. Many men will remember the memorable match with St. Thomas's when he was carried off the field a quarter of an hour before time, and we, in consequence, lost by a try. Mr. Clarke took the double qualification of the Conjoint Board in April of this year, and was reading for the final M.B. Cambridge when his untimely death occurred.

With the Army Medical Corps in South Africa.

(BY OUR SPECIAL CORRESPONDENT.)

(Published by permission of the Director-General of the Army Medical Service).

19th Brigade Bearer Company,
Germiston, near Johannesburg,
Tuesday, June 12th.

A FIELD HOSPITAL IN ACTION.

We, in Hamilton's column, have been trekking hard every day; and eventually had the satisfaction on Monday, June 4th, of sending in an officer to Pretoria to demand the surrender of the town. The following brigade orders came round to us the next night. "Brigade orders by General Smith-Dorrien, D.S.O., commanding 19th Brigade, Pretoria, 5th June, 1900.

1. Countersign 'xxxx."

2. The 19th Brigade has achieved a record of which any infantry might be proud. Since the date it was formed, 12th February, 1900, it has marched 620 miles, often on half rations and seldom on full. It has taken part in the capture of ten towns, fought in ten general engagements and on twenty-seven other days. In one period of thirty days it fought on twenty-one of them, and marched 327 miles. Casualties between 400 and 500. Defeats, nil.

By order, F. S. INGLEFIELD, Brigade-Major."

The ten towns are—Jacobsdal and Bloemfontein, which we left on April 21st, Thaba 'Nchu 26th, Winburg May 6th, Ventersburg 10th, Kroonstad 12th, Lindley 18th, Heilbron 22nd, Johannesburg 30th (after crossing the Vaal on the 26th), and Pretoria June 5th.

But the work of the field-hospital section, which alone has accompanied the brigade from Bloemfontein, has been chiefly that of attending to sick and not to wounded. On most days we have seen and heard the 12-pounders and pom-poms at work, and there has been a certain amount of skirmishing; but this has usually affected only the mounted infantry and cavalry, who move on the flanks of the main body, and brush the enemy away before our advance. The mounted troops have been treated by the staff of the New South Wales Bearer Company and Field Hospital. The only two occasions on which your correspondent has seen many wounded were after the battles of Thaba Kopje and Doornkop.

The battle of Doornkop took place on Tuesday, May 29th. Doornkop is a large district covering the western end of the Rand. In the western part of this district Dr. Jameson surrendered in 1896 after a running fight. In the eastern part of the same district a fortnight ago Hamilton's force won its last victory before entering Johannesburg. An officer of the Gamerou Highlanders in the 21st Brigade was present in both engagements. In this last engagement—so the story goes—the Gordon Highlanders were ordered to advance upon a commanding ridge from the front, and, if they met with a heavy fire, to lie down and await the development of the flank attacks by the rest of the column. The enemy's fire was heavy; but the veld, which purposely or by accident had been burnt to a cinder, made a background against which the khakhi uniforms made a conspicuous target. It was a choice between retreat and advance; hence the gallant charge of the regiment, which resulted in upwards of a hundred casualties, the captains of the two leading companies responsible for the movement being one fatally and the other severely wounded.

In the second line of transport we heard distant artillery fire most of the morning; and at 2 p.m., while our teams were spanned out to water and graze and we were lunching in the shadow of our wagons, the sharp sound of musketry fire began. Our attention, however, was for some time occupied by a veld fire, which started to windward of us by a cooking fire carelessly left to itself by some of Roberts' Horse, was caught by the breeze, and simply rushed downhill as fast as one could walk towards the ammunition wagons. All hands turned to with empty sacks and greatcoats to try and flog the fire out; but it was only due to a lull in the breeze that the attempt was at last successful, when the flames had already rushed under and past the wagons, fortunately without doing any harm, except to the harness, which was lying out on the ground.

The firing ceased soon after 4; and at 5 orders were received to pitch the field hospital. The bearer company with their wagons were already on their way to fetch in the wounded, one officer and several men having been sent out in advance to dress and collect patients in readiness for the ambulances.

According to the book the wounded are in the first place—Step I.—dressed in situ by their regimental doctor with the help of his regimental stretcher bearers and the staff of the bearer company. Step II.—They are taken to the appointed dressing station, where they are seen by the officers of the bearer company, who revise the dressings and perform any necessary operations that cannot be deferred. (N.B.—There may be more than one dressing station to a brigade, especially if the fight has extended over a large area). Step III.—From this the wounded are gathered still on hand-stretchers into one collecting station on the nearest and most convenient road, and there await the ambulance wagons which remove them—Step IV.—to the field hospital.

The field hospital is pitched in safely behind a kopje, or in and around a house, close to a road and to water-supply, but all the previous work is carried out more or less under fire by the bearer company; and is proportionately curtailed. As a fact most of the work by the bearer company is done after the firing has ceased, and its main object is to get the wounded collected and dressed ready for the ambulances before nightfall. The book rules in consequence fall to the ground. The dressing and collecting stations are usually combined; or else, as on this occasion, there is found to be no need for a dressing station, the wounded being simply collected into groups of two or three, and the ambulances moving to them instead of their moving to the ambulances. Indeed, in this country where there are no walls and few kopjes, and the ambulances can

go everywhere, one can follow the rules of common sense. The field-dressing is applied indiscriminately by the regimental doctors and the officers of the bearer company; the men naturally dispose themselves in groups around the most severely wounded, and the wagons and stretchers carry them off to hospital as quickly as possible.

The elaborate system described above is probably more or less necessary in mountainous or in cultivated and populous country. Here, however, the only question is as to how far the ambulances should be brought under fire. On the one hand, the officers of the New South Wales Bearer Company have their wagons driven by horses, and believe in galloping them about the field under fire, picking up the wounded one or two at a time, and taking their chance of being wounded with the rest of the brigade. The matter is urgent, as the sun sets at 5, and if you wait till firing ceases before beginning to collect your wounded, you may be obliged to spend the night in searching for them. In this kind of country, therefore, the galloping system receives strong support, and it is certainly the more picturesque. On the other hand, our ambulances are cumbersome, and have been worn out as it is by simple trekking; so that galloping work across the veldt would be disastrous to them. Still more disastrous would it be to the animals. A considerable proportion of our mules have been worn out by the constant work and scanty food as it is, and if they had harder work imposed upon them, and if they lost a few more by shell and rifle fire, the bearer company would be completely disabled. And it must be realized that in proposing the heroic system, the red cross would be no protection in any war; as the enemy cannot be expected to spare the combatants on account of the ambulance wagons coming to their relief. The Australian officers who prefer this system freely admit the point, and in consequence discard the red cross altogether. The conclusion to which this war will probably bring us is that our cumbersome ambulance wagons, carrying only two lying-down cases apiece, must be totally revised; and that if a light metal frame-work be substituted, with strong bicycle wheels, designed to carry half a dozen stretchers apiece, the transport will be greatly relieved, and the galloping system may be allowed at the expense of a few casualties.

However, in the action of Doornkop there were not more than 100 casualties in the 19th Brigade, of which some fifteen were buried on the field by the Presbyterian chaplain attached to the Gordon Highlanders. With three exceptions—Canadians attended to by the Canadian doctor, and safely housed for the night in a native kraal—all the remainder were gathered into the field hospital by half-past eleven at night.

Meanwhile, this quarter-section of a field hospital had been uncommonly busy. Joining forces with the two transport wagons of the bearer company, it had mustered in all eight tents, and had erected them with difficulty on on the side of a stony kopje, never intended to receive wooden tent-pegs, or to act as a bed for wounded soldiers. The position was chosen mainly because the kopje acted as a most useful landmark to the ambulances; but it is to be hoped that in future some simple but characteristic light, perhaps a revolving lantern, may be chosen as a mark of the field hospital after dark; and if the hospital were always to be kept separate from the camp by a hundred yards or so, the signal would be respected, and need be no indication to the enemy of the position of the troops. On this occasion, for instance, the troops were encamped at two miles' distance from the hospital. Such a distinctive light would also be of great use in the ordinary night's encampment after a day's trekking.

The field hospital had been erected. The serjeant and corporal cooks had made an ant-heap into a fire-place, and were preparing hot milk, tea and bovril over a roaring fire made of barbed-wire fence-posts. By 5·30 the first batch of wounded had arrived and were lying in a row, wrapped up in their blankets, the worst cases on stretchers, the rest on the ground outside the tents. The serjeant-major, with two rows of medal-ribbons on his breast, went round systematically to every patient to distribute hot drinks and rum. The two chaplains of the brigade went round talking to the men, distributing cigarettes, keeping the "nominal roll," carrying lights for the medical officer, and cheering everybody in turn. Your correspondent, the only medical officer available, having never before seen a field hospital at work after action, struggled with the arrangements in general, and every now and again was able to dress a case, or superintend an R.A.M.C. orderly in dressing a simple wound. One tent was from the first kept as a surgery. The rest were filled as they were erected with patients carried or helped out from the surgery. The surgery tent, an ordinary bell-tent twelve feet across, was supplied with two panniers, which stood on the right of the door, to support one stretcher at a time, and so enable the worst cases to be attended to without more discomfort than was necessary. On the left of the door-way were the antiseptic and fracture boxes, with an orderly to distribute their contents. Beyond them on the left side of the tent, and again at the further end, two other orderlies were able to treat slight cases sitting on the ground. But the work of the medical officer in charge, supervising the slight cases, trying himself to dress the severe cases, and being constantly called away from the surgery tent, was difficult and vexatious in the extreme. "Where shall this tent be pitched, Sir?"; and he had to go and explore the ground in the neighbourhood. "I ain't been looked at yet, Sir," remarked two or three Gordons, as he nearly tripped out over them in the dusk. "I 'aven't got no blanket, Sir" complained a fourth poor chap, looking very cold in his kilt. "There won't be enough Bovril to go round, Sir" said the cook. "The General is here, Sir" reported a corporal. "May we have our stretcher, Sir?" asked four Gordon stretcher-bearers, who had carried a fractured thigh two miles, and would now have to transfer him to the ground. "Twelve more wounded, Sir," said the staff-sergeant, coming up with some of the ambulance wagons. "The officers' tent has got four cases in it already, Sir; where shall Captain —— go to?" "That corporal, Sir, is dying; will you come and see him?" "Mr. ——, Sir, is ready for you to dress him; he has been waiting rather a long time."

Fortunately, as matters were reaching a climax, Providence arranged that three Australian doctors should miss their way; and they, with the doctor of the mounted C.I.V., his veterinary colleague, and his orderly came and offered their services. All turned to with a will. The consulting surgeon from Sydney stood on one side of the tent and dressed cases. The C.I.V. trio stooped on the other side and dressed other cases. The other two Australians kept count of every case as it was brought in, fed the surgery tent, and themselves dressed many cases in turn, just as they were, lying out on the ground; while your correspondent was free to put his hands in his pockets and answer questions. It was dark and there were but three lanterns and a few naked, flickering candles. It was horribly cold, and the troops had been without rations, except of meat, all day and with no prospect of any for the next. The supply of milk and bovril in the hospital was limited; the supply of spare blankets still more so. However, help came from various quarters. The staff sent some of their private blankets, and lent others that once belonged to Boers. The supply officer raked in some extra supplies from somewhere. The N.C.O's. and men worked like slaves. The adjutant of the Gordons and twenty-five of his men, despite the fatigues of the day, brought down from their camp, two miles off, the kits of the wounded Highlanders, and were up till nearly midnight distributing them. Above all, the surgical work progressed slowly but steadily.

It is a question how far the first field-dressing should be changed on admission to the field hospital. Formerly the wounds were so lacerated and the field-dressing applied under such difficulties, that the best surgery would certainly require every case to be thoroughly examined, washed afresh and redressed as soon as possible. And even now this course ensures that no injured artery or fractured bone will be overlooked, that the dangers of the wound will be thoroughly realised, and practically all danger of sepsis avoided. Furthermore, there is hardly a man, however well educated, who does not feel easier in his mind, probably also in his wounded part, by the renewal of a dressing. One officer, for instance, with a slight wound of his forearm, to which the field-dressing had been well applied, consented willingly to have it left alone till next morning. But until his arm was dressed next morning he posed as a martyr in consequence. If it is so with an officer, still more is it so with the men; and many medical men would prefer on such an occasion to yield to this somewhat excusable feeling, and dress the wound at once. Two of the Australian officers acted on this principle, and it was not therefore till two o'clock in the morning, after nine hours' continuous work, that the last case had been disposed of for the night.

The third Australian officer, however, one of the leading surgeons in his country, was of a contrary opinion. Most of the field-dressings—with iodoform powder, perchloride gauze, and perchloride gauze bandage—had been thoroughly well applied; and the patients were so comfortable that they had been smoking and discussing the events of the day from the first, and had even been silenced by order while being dressed in the surgery tent. If his advice had been followed throughout, only ten per cent. of the cases would have required re-dressing, simply those—especially wounds of the trunk—where the dressing had slipped, those where the dressings had been saturated with blood, and the cases of compound fracture. In that way all dressings would have been finished before midnight, the patients would have been spared, on an average, each an hour's waiting in the cold, and even the next morning, when it is necessary to inspect carefully every case, probably only a few more dressings would be necessary.

The experience of this war shows that, unless it hits bone, the Mauser bullet causes so slight an injury, as practically to ensure a straightforward recovery, provided the field-dressing be properly applied. Renewal of the dressing under the difficult conditions of work in a field hospital during action or immediately after it, is more likely to introduce than to remove the dangers of sepsis. In this country where there is no running water, and the water obtainable is filthy, where fuel is scarce and it is impossible to boil any large quantity of water, where there is a great deal of work to be done in a short time, when the night is bitterly cold, hands are rough and indurated with the dirt of six weeks' dusty travelling, and the amount of dressings is limited, asepsis is impossible, and thorough antisepsis difficult. Probably this latter course, therefore, is the best, although it is less heroic.

It will probably surprise many to hear that it was not found necessary to perform a single operation; and the only operation which was considered as definitely indicated, an amputation of the finger, was able safely to be left till daylight, There were no obvious shell-wounds, no shattered limbs, no head-injuries with certain signs of compression, no cases of uncontrollable hæmorrhage. Exception must be made of three or four moribund cases; but under the circumstances operation could only have accelerated the end. Had there been the complete equipment of a field hospital, one would have been strongly inclined to perform laparotomy on an officer who was shot in the abdomen, and died during the evening from internal hæmorrhage, and on a private in the Gordons who died from a similar cause next morning; or to trephine two cases of head-injury who likewise died within a few hours from cerebral hæmorrhage. But in all these cases the prognosis would have been bad even in a Guy's theatre; while in slighter cases it is better to trust to luck and a firm bandage. When we reflected on the matter next day, we did not regret our treatment in any one of these cases.

To recapitulate the cases treated, we may classify them as follows, the cases being at once labelled officially for telegraphing to the War Office as either slight, severe or dangerous, the site of injury being only shown in the returns in the case of officers:—

A. Dangerous:—

Fractured Skull (2 subsequently died)	...	4
Neck (brought in dead)	...	1
Chest	...	1
Abdomen (2 subsequently died) ...	...	3
	—	9

B. Severe:—

Neck	1	
Chest	2	
Abdomen (1 subsequently died)	2	
Back (1 subsequently died)	2	
Fractured Limbs (Thigh 4, Legs 2, Arms 3, Patella 1, one of thigh subsequently died)	10	
	—	17

C. Slight (*i.e.*, flesh wounds) without complication:—

Head (*i.e.*, Scalp and Face)		4
Neck		0
Chest		3
Abdomen		1
Upper Limbs—Shoulders	4	
Arms and forearms... ...	13	
Hands and wrists	1	
	—	18
Lower Limbs—Buttocks and thighs ...	16	
Legs	10	
Feet and ankles	5	
	—	31
		—
		57

To this may be added one case severely burnt about the legs by a veld fire, giving a total of

Dangerous	9
Severe	17
Slight	57
Burn	1
	—
	84

Of these, ten were officers, one being the doctor of the Gordons, who gallantly continued work under fire after receiving his wound, supported from case to case by two orderlies.

A few cases were given morphia injections, but most were quite comfortable; and as it was past two o'clock before the cases had been dressed and packed away for the night, and all was quiet, it was not considered advisable to make a systematic round for this purpose, which would have involved opening up the tents and waking up most of the eighty-four. With the full equipment, however, of a field hospital it would be easy and perhaps advisable to give morphia more freely to fracture cases, and cases where hæmorrhage is suspected or feared, it being always born in mind that sleeplessness is seldom a difficulty with healthy soldiers under the healthy conditions of active service, unless the wound is actually painful; and this is seldom the case on the first night unless bone is involved. Pain, if it comes at all, comes later as the result of tension from inflammation.

It was a bitterly cold night, and consequently the men were not so sorry as they might otherwise have been to be packed ten in each tent. The officers' tent held six, four being on stretchers, and the rest in their valises on the ground. The surgery tent was filled. The ambulance wagons were filled. And there remained three men who preferred to remain outside, rolled up in their blankets; a few minor cases of sprained ankle and sore feet, and one man who, being delirious, could not refrain from banging his neighbour's head. He had, therefore, to be put outside with an orderly sleeping at arm's length on either side. By two o'clock the friendly doctors had departed, to lose their way again, as it eventually turned out, and be entertained by the General; while by three o'clock the last of us was tucked into his valise under a starry, frosty sky.

The next morning we were up again at five, and were busy from that time onwards in preparing the "nominal roll of killed and wounded" for the brigade-major, and a duplicate for the principal medical officer to be forwarded to the Director-General; in re-examining every case and dressing a few; in distributing again the various articles lent privately for the occasion, and in preparing patients and camp for the inevitable move into Florida, one of the suburbs of Johannesburg. Even with four ambulance wagons lent for the purpose by the bearer company of the 20th brigade, many men wounded in the groin and thigh could only be given sitting-up accommodation; but finally they were all packed in; by five o'clock the hospital of the night before was again merely veld, and by ten o'clock every patient had been berthed in a boarding-house, taken over for use as a temporary hospital.

Here ended our acquaintance with the cases, and the clinical results must be looked for in the report of the Australian doctors, who promptly set to work, trephining three cases and operating on several others with the better conditions, and the greater leisure at their command. Such then is the work of a field hospital in action. It is simply temporary work. You bandage, you feed, you warm, you stimulate, you allay pain. But under such conditions as these you cannot treat radically. You must wait at least to find a building, a proper supply of water, and a sufficiency of apparatus, with time for the purpose. These conditions were found the next day in Florida; and the delay, which under the circumstances was inevitable, probably made no difference to most of the cases.

From that day onwards there has been little to relate. On the afternoon of Saturday, the 2nd of June, when riding into Johannesburg from the camp four miles out, the writer was greeted cheerily by a one-legged Boer driving out to his tin-house close by. It was the Field-Cornet Pretorius, who was taken at Elandslaagte, wounded through the knee, had his leg amputated at Wynburg in December, and was allowed by Lord Roberts to return home in February, as being no longer able to fight. He had just been driving in to see Lord Roberts and thank him for his kindness. He was glad to see an old friend, but not in Johannesburg. Certainly they had been beaten, but they had dared what no European nation had dared, to fight the British nation; and what could you do with odds of one against a hundred? As to his leg, the sinus had broken out again, but was now all but healed.

After a few hours in the deserted wilderness of Johannesburg and its tin-built suburbs, we returned to camp to find a native driver had been run over, while the worse for some liquor, which he must have stolen, and had ruptured his urethra. The brigade was under orders to move at daybreak next morning, and operation on the spot was obviously impossible. Florida and its boarding-house

were not only full to overflowing, but were four miles off. It was decided to try Johannesburg. The patient and your correspondent made themselves as comfortable as possible on stretchers on the floor of a buck wagon, left camp at half-past eleven, and eventually found the civil hospital of Johannesburg at two o'clock in the morning—a splendid building in fine grounds, one whole wing having been built by Barnato, and very well equipped. The doctor of the Swiss ambulance, sent out to help the Boers, was woken up and was most cordial in his welcome. Although built for only 230 beds, the hospital contained nearly 800 patients, mostly civilians suffering from enteric fever and other diseases, very few being wounded Boers (indeed very few Boers have been wounded in these parts). However, room was found under the verandah for the Kaffir boy, who was promptly taken into the fine theatre of the hospital, and left to the care of the Swiss doctor and his colleague, a Swiss Sister of Mercy, and the German-Jew porter.

The camp was reached again at five, and a long day's trek followed. On Monday the 4th Hamilton's column encamped after heavy artillery fire within four miles of Pretoria, and sent in an officer to demand the surrender of the town. General Botha did not keep his appointment next morning with Lord Roberts, who entered the town without opposition, and at two in the afternoon there began the long procession of troops past the Commander-in-Chief, which must by now have become historic. One faced the splendid Raadzaal, and watched first the rescued officers cheering with all their might from the Grand Hotel, then the silent crowd of natives, Jews, women and children, with a few puzzled-looking burghers thrown in; the endless stream of royal artillery and naval guns, infantry and mounted infantry, kilts and khakhi, mules and oxen, ambulance wagons, well-known generals, saluting amidst cheers and then taking up their position with the chief; and last of all the chief himself, hardly to be seen for the number and splendour of his staff. The bands played and the pipers piped. It was the Jubilee procession over again. And the army went to bed happy. The complete field hospital appeared from Bloemfontein next day. And after two days' rest the 19th brigade turned its face southwards to garrison the railway as far as Vereeniging and beyond. Its work was done. F. E. F.

Nursing News.

MATRON'S OFFICE.

On Wednesday, August 22nd, Nurse Candy left the hospital on completing her three years' training. Probationer Whiteman has been appointed to succeed her as head nurse in Martha ward.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

The Prevalent Diseases of the Campaign.

No. 8 General Hospital,
Bloemfontein.
June 9th, 1900.

(*Continued*).

In reference to the morbid anatomy in enteric fever, the appearances are much the same as those we see at home. Of about sixteen cases on which I have made autopsies, in about half there has been extensive affection of the Peyer's patches in the lower part of the ileum, but in only two any inflammatory condition in the cæcum. The number of patches affected was, on an average, about a dozen. In two cases—and these were in patients who died early in the disease with high temperatures and all the symptoms of severe toxæmia, with twitchings of the arms and legs, and delirium followed by a semi-comatose condition before death—the swollen patches were numerous and several of them very large, about two and a quarter inches in diameter, and prominent. There was no ulceration. I have several specimens preserved in formalin which I intend bringing back with me. In two or three cases there were very few patches affected, and in one there were only two small ones to be found about two feet above the cæcum, thereby clinching the diagnosis. The mesenteric glands were much enlarged, red and soft in all cases, but in none of them was there any sign of caseation. The mucous membrane of the bladder was red and injected in two or three cases. The spleen was always enlarged and soft. In two cases, where the patients had died after rather lengthy illnesses there was œdema of the bases of the lungs and a little fluid in the pleural cavity. Two patients had died from hæmorrhage; in one of them there was the site of bleeding in the centre of a patch two feet above the ileo-cæcal valve; in the other there was blood in the entire length of the alimentary canal from the stomach to the anus, and it was quite impossible to find the seat of hæmorrhage; this man also had severe epistaxis before death. In one patient, who is said to have died suddenly, the peritoneal cavity was full of pus but no site of perforation could be found.

Dysentery.—Clinically (i.) *acute*, and (ii.) *subacute* or *chronic*, are useful distinctive terms. By the former one would imply cases which last from a few days to a fortnight, with perhaps a continuance of more or less diarrhœa for some time after the true dysenteric symptoms have passed off; and by the latter those lasting from a fortnight to three months, which seems to be generally the longest time any of these cases endure, as the patients almost invariably become exhausted and die before that period has elapsed.

In the acute cases, diarrhœa, which has lasted about twenty-four hours, is followed by the passage of mucus, which rapidly becomes mixed with blood, and in less than forty-eight hours from the onset, in many cases, the patient is passing bright red blood, accompanied sometimes by mucus, at very constant intervals.

Associated with the passage of mucus and blood, the tenesmus is severe, but the griping abdominal pain so commonly described has not appealed to one in the majority of cases as being a very distressing symptom in the more acute forms. The temperature for the first few days is mostly raised, but it is quite rare for it to go higher than 101°, and generally 100° is about the highest. This may last only twenty-four hours, and very rarely lasts more than a few days, when it falls to normal, and during the continuance of the disease it remains, roughly, at normal, with intervals of subnormality. During the height of the disease the patient wears an anxious, drawn, expression, and in more so than any other malady with which I am acquainted, he feels really frightened about his own condition. The face is pale, the pulse small, and quickened out of proportion to the height of the temperature. The tongue is generally covered with a thick white fur. There is often difficulty in micturition, but I have heard of no case of serious retention of urine. Should the dysenteric symptoms continue more than a few days the patient becomes rapidly emaciated. In the fatal cases death is preceded by a rapid thin pulse, and very often by troublesome vomiting, which will yield to no treatment. The patient commonly remains conscious until within a very short time of death, which is usually painless. If the patient recovers, the passage of mucus and blood gradually ceases, often from the fifth to the tenth day of the illness, and the stools become solid by degrees, after a few days of ordinary diarrhœa, more or less profuse.

A large number of cases of acute and chronic dysentery follow directly upon an attack of enteric fever, often commencing about a fortnight after the temperature has become normal.

There are many cases in which the passage of blood and mucus is in such small quantities and passed for such a short period, often only for one or two days, that it can be hardly be termed true dysentery. This condition has been experienced by many of the medical officers in this hospital and in others in the neighbourhood.

Chronic dysentery generally follows upon an acute attack, although occasionally it starts as a simple diarrhœa which may have been persistent for many days or even weeks. These cases appear to follow on diarrhœa, the treatment of which has been neglected.

The intermittence of severe dysenteric symptoms seems to be a common feature of the chronic form. After the patient has been passing blood and mucus for a few days the stools become more natural or he may even be constipated for a day or two, then follows again the passage of dysenteric stools. This condition of things may go on with more or less regularity for several weeks without any apparent modification by treatment until the patient gradually recovers or becomes exhausted and dies.

The emaciation in chronic cases is very marked, and the patient for several weeks before death has the exact appearance of a man rapidly dying from malignant disease. Under these conditions patients appear to have aged to a remarkable degree; on several occasions one has mentally put down a patient to be forty-five or fifty when he has not been more than thirty or thirty-five years of age.

Griping abdominal pain is far more severe and persistent than in the acute condition and generally comes on in paroxysms lasting for several hours. The patient usually uses the bed-pan much more often during the night than in the day. This is almost invariably the case. A symptom of the worst augury in chronic dysentery is vomiting, which is often of the most persistent and obstinate character and yields to no treatment. Complications and sequelæ are rare. Rheumatic pains in the feet and calves, slight pleurisy, and deafness seem to be the most common. No case of hepatic abscess have I seen or heard of out here. As regards medicinal treatment, the two drugs that are principally relied upon are Magnesium Sulphate and Ipecacuanha. In the acute cases I infinitely prefer the latter, having seen it followed by the best results where Magnesium Sulphate has had no beneficial effect. The best way to give it seems to be in 20 gr. doses every two hours during the day, but only about twice during the night. It is also advisable to give on about two occasions every night (at about 6 p.m. and again at midnight) 10 grs. of Pulv. Doveri or one Pil. Saponis Co. This gives the patient the benefit of a little sleep and tends to relieve him of abdominal pain. One generally finds the first dose or two of Ipecacuanha is followed by vomiting about one hour after its administration, but if the drug is "pushed" this almost always passes off quickly and does not recur.

The majority of the medical officers greatly prefer Magnesium Sulphate. This is best given in ʒi. doses of the saturated solution until about ʒiij. have been given, this followed by a simple astringent mixture and the Magnesium Sulphate repeated in a day or two if the symptoms are not relieved. I have mostly found that Magnesium Sulphate unless given with a considerable quantity of Opium gives rise to severe abdominal pain, and that if it checks the passage of blood and mucus for a while it generally recurs. In the more chronic forms Ipecacuanha does not seem to have the same satisfactory value, and the best treatment seems to be Magnesium Sulphate given in small doses at the time constantly for a day or two, to be followed by a mixture containing Bismuth and Morphia. This latter is certainly the most comforting to the patient, and in the cases in which there is no tendency to improve this is the most valuable sedative. What one has found the best way of giving it is in a mixture containing Bism. Oxycarb. gr. xx. and Liq. Morph. Hyd. ɱxv. to the dose. Brandy one has found, unless there is much hæmorrhage, to be most valuable in both acute and chronic cases. It may be given in large quantites, and with the most beneficial effects.

The descriptions of the *catarrhal* and *diphtheritic* forms in Dr. Taylor's book (Ed. 1893) apply almost exactly to

the conditions found after death out here. The *catarrhal* is the more common, and I have found it in all the cases of *acute* and *subacute* dysentery on which I have made autopsies (about 10). The extent to which the bowel is affected varies very markedly in different cases. The inflammatory condition (which consists of extensive injections of the mucus membrane with blood, masses of semi-organized, blood-stained mucus adhering here and there to the wall of the bowel, irregular-shaped ulcers, some as long as an inch, others nothing more than small pits, which would hardly admit more than the head of a pin) in most cases extends from just above the anus to the cæcum; but the lower two or three feet of the ileum, although not ulcerated, are red and injected. One has seen two cases where death followed with only the smallest amount of inflammation and ulceration situated over an area of about eight inches in the region of the sigmoid flexure. I shall be bringing back a fine specimen of the *diphtheritic* form, which shows the intestinal wall greatly thickened, preserved in formalin. This was taken from a seaman from H.M.S. "Doris," who died with severe pain and great emaciation after an illness of nearly three months.

A. H. B. KIRKMAN.

Surgery at Sea.

DURING the passage of the "Egypt" through the Mediterranean a quarrel arose in the native quarters. A big Pathan worried a small Seediboy fireman, who retaliated by driving a sharp-pointed knife into the abdomen of his oppressor. Hence this story.

The Pathan, supported by a shouting, wildly gesticulating crowd of partisans, was brought, all gory, to my surgery, immediately after church in the saloon. The omentum was protruding from a wound below the left ribs about two inches long. The carpenter's bench (nine feet long) served as a table, the spar-deck alley-way as a theatre. A stewardess-nurse was in attendance; a Parsee doctor administered chloroform with varying uniformity. Two white doctors (real *white* men) lent me freely their heads and their hands. To Ausculapius have I sacrificed a young fowl for their sending! Hushed were the billows. The chef stewed the weapons in the galley, every microbe was parboiled. Heroic efforts were made to obtain antisepsis in all things, which a crowd of willing hands rendered as abortive as possible, nor would they be denied. A veritable swarm of Jack Horners.

Twenty per cent. carbolic lotion is not the best strength for the peritoneum and hands; it was offered by our nurse. Quoth the surgeon, "If the gut is punctured he will die; the Seediboy will also perchance attain an hempen collar three sizes too small for life." The incision was, therefore, improved, and the intestine in the locality brought to view. It was a fair intestine of smooth unruffled surface. With shameful needles—this ship does not carry a Coels—and chromic gut (it is better than packing thread or No. 20 cotton), the absolute hiatus in the abdominal wall was rendered merely potential. Soon after was vomited nearly a pint of bright red blood, shot with a few grains of rice. Then in the sweat of their brows did the surgeons ponder cause—deeply libating—with many "it is clear" and "it seems to me," and he who knew least talked most, to whom others listed a while, then spoke, unheeding that they were themselves unheeded. Thus in the multitude of consultants is wisdom sought and found. Then was the pibroch heard. Uprose the Caledonian in martial tones proclaiming, "If ye dinnae steetch up the hole in his waem from whilk the bluid comes, he'll dee."

All was consternation and affright. The surgeon had called for—the table. In an anæsthesia semi-consciousness, once more I pried into the innermost man, reviewing his stomach fore and aft, nor found I scratch. Having flushed the abdomen through a stomach-tube (virgin), and a gauze drain having been supplied, once more the sorry Pathan sought his couch. Another pint of hæmatemesis in the night. Then severe diarrhœa occurred with a rise of temperature. The patient also rose on the fourth day; he could not be restrained. His wound healed by the primary intention, and on the thirteenth day he materially assisted in obtaining a complete rest from the sea for the Seediboy of eighteen months. Whence came that hæmatemesis? Who shall say? Not

VAUGHAN PENDRED,
Surgeon ss. "Egypt."

Bombay.

The Chronics.

(With apologies to Mr. Rudyard Kipling.)

When the latest exam. is finished and their brains are sapless and dried,
When the youngest chronic is fading and the oldest chronic has died,
They shall rest for they think they need it, lie low for a session or two,
Till the fear of the Hall or the College shall drive them to work anew.

Then though they be good they're not happy, for they sit on a hard-backed chair
And splash at a quire of foolscap with the pens of a mad despair;
They find new saints to swear by, and the old ones—at one haul,
And they use every one at a sitting, and never get tired at all.

And only their fellows shall praise them, and only examiners blame,
Yet none of them work for money and none of them care for fame;
And from each at the end of the sitting diplomas are just as far,
For they write of the things as they think them, and not of the things as they are.

G. T. W.

Pass List.

University of London, July, 1900.

CORRECTIONS AND ADDITIONS TO PASS LISTS APPEARING IN LAST "GAZETTE."

INTERMEDIATE EXAMINATION IN SCIENCE (Second Division).—A. G. Jones.

PRELIMINARY SCIENTIFIC EXAMINATION.

EXAMINATION FOR HONOURS.—CHEMISTRY AND EXPERIMENTAL PHYSICS (Third Division).—F. M. Longson.

PASS EXAMINATION.

ENTIRE EXAMINATION.—For "R. J. Pentley" read "R. J. Bentley." For "G. Bellingham Smith" read "E. Bellingham Smith."

CHEMISTRY AND EXPERIMENTAL PHYSICS.—For "T. R. Cook" read "I. R. Cook."

I. R. Cook, A. B. O'Brien, W. P. Purdom, and R. O. Williams have now completed the examination.

BIOLOGY.—G. Hamilton has now completed the examination.

Appointments.

CIVIL.

BOVILL, F. M., L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., has been appointed Medical Officer for the Fourth Sanitary District of the St. Alban's Union, *vice* F. M. G. Smith, deceased.

BUSTEED, J. H., L.R.C.P., L.R.C.S. Edin., has been appointed Medical Officer for the Ellesmere and Welshampton Sanitary Districts, and for the Workhouse of the Ellesmere Union, *vice* J. W. Roe, resigned.

MARTIN, F. J. H., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Surgeon to the Perim Coal Company and Port Surgeon at Perim, Arabia.

NAVAL.

STAFF-SURGEON W. J. MAILLARD, V.C., is appointed to the *Archer*, and STAFF-SURGEON C. M. BEADNELL to the *Barracouta*.

SURGEON CYRIL SHEPHERD is appointed to the *Royal Arthur*, additional for disposal, and CHARLES R. NICHOLSON to the *Nile*.

MILITARY.

SURGEON-CAPTAIN S. A. MUGFORD, 2nd Volunteer Battalion of the Essex Regiment, resigns his commission.

The following gentlemen have been elected Examiners at the Royal College of Physicians of London:—

EDWIN COOPER PERRY, M.D., F.R.C.P., *Materia Medica and Pharmacy*.

WILLIAM HALE WHITE, M.D., F.R.C.P., *Medical Anatomy and Principles and Practice of Medicine*.

MARCUS SEYMOUR PEMBREY, M.D., F.R.C.P., *Physiology*.

Sport.

Cricket.

GUY'S v. GRAVESEND.

This match was played on July 4th, on a soft wicket. Guy's batted first and made 158, thanks to a fine 66 by Barber. Gravesend replied with 132. Guy's thus won by 26 runs. Both teams were entertained at lunch by Dr. R. S. Bryden (an old Guy's man) in the most hospitable manner, and a very enjoyable day was spent. Score:—

GUY'S.

H. Barber, lbw, b Jackson	66
S. C. Bowle, b Castley	0
F. Morres, c Bowman, b Castley	9
H. Langdale, b Collins	11
R. C. Poyser, b Collins	4
K. V. Trubshaw, c & b Collins	8
H. R. Grellet, b Collins	0
M. C. Wetherell, c Bryden, b Troughton	24
E. A. Collins, b Castley	0
J. T. Hicks, c Troughton, b Castley	16
C. M. L. Cowper, not out	10
Extras	10
Total	158

GRAVESEND.

L. H. W. Troughton, c Wetherell, b Trubshaw	0
A. B. Tromer, run out	9
T. J. P. Castley, c Barber, b Cowper	26
F. H. Stevens, b Cowper	5
Collins, not out	66
F. W. Thompson, c Collins, b Cowper	6
C. C. Counes, b Wetherell	5
L. C. Troughton, c & b Poyser	3
R. S. Bryden, b Wetherell	2
A. Bowman c Collins, b Bowle	7
S. W. Jackson, b Wetherell	1
Extras	2
Total	132

GUY'S v. EASTBOURNE.

On the first day Eastbourne made 380, of which L. G. A. Collins made 105. Guy's made 43 for 2 wickets in forty minutes. The next morning our total was raised to 181, thanks to a fine stand by Tolhurst and Cawston, who added 71 for the eighth wicket. On following on, we only got 144, Cawston again batting well for 30. We were one short, but found a substitute. Scores:—

EASTBOURNE.

L. G. A. Collins, c Wetherell, b Harris	105
C. A. Bush, c Harris, b Wetherell	3
H. B. Chinnery, b Harris	12
F. W. Bush, b Harris	34
W. F. Noakes, c Harris, b Trubshaw	48

Dr. Pavri, c Tollhurst, b Harris	65
S. Metcalf, c Barber, b Cooper	27
C. A. Leach, not out	35
Nixon, c Harris	4
C. W. F. Winford, b Trubshaw	4
R. Collins, b Trubshaw	26
Extras	17
Total	380

GUY'S.

	1st Innings.	2nd Innings.	
K. V. Trubshaw, b Nixon	3	c & b Noakes	22
H. Barber, c Chinnery	17	lbw, b Pavri	2
F. Morres, run out	23	c Collins, b Pavri	20
H. M. Langdale, b Nixon	11	c & b Collins	15
M. C. Wetherell, c Collins, b Nixon	4	c & b Collins	25
Harris, b Pavri	17	c Chinnery, b Collins	7
H. R. Grellet, c Collins, b Pavri	0	not out	5
H. M. Tollhurst, not out	37	b Pavri	0
C. M. X. Cowper, c Nixon, b Chinnery	19	b Nixon	4
A. E. Causton, c Collins, b Nixon	34	c Collins, b Noakes	30
A Substitute, b Nixon	10	b Nixon	1
Extras	6		13
Total	181		144

CRICKET RETROSPECT.

The cricket season as far as club cricket was concerned has been fairly successful. The record would have been much better had we not lost the last two matches with very weak teams. Seven matches were won, three lost and two drawn, both the last were considerably in our favour. The only Cup Tie played resulted in disaster.

The following are the averages:—

BATTING (6 innings or more).

	No. of Innings.	Times not out.	Most in Innings.	Number of Runs.	Average.
H. Barber	14	1	115	534	38·29
F. C. Wetherell	9	0	107	270	30
H. M. Langdale	9	0	77	232	25·77
K. V. Trubshaw	14	2	38	273	22·94
J. M. Brydone	10	0	53	228	22·8
F. Morres	13	1	62	258	21·5
C. M. L. Cowper	10	4	31	124	20·66
G. S. Graham-Smith	9	1	48*	159	19·87
R. C. Poyser	10	1	36	133	13·3
M. C. Wetherell	14	0	26	170	12 14
(Less than 6 innings).					
A. E. Cawston	2	0	34	64	32
H. M. Tollhurst	3	1	37*	41	20·5
J. T. Hicks	4	0	28	73	18·25
S. C. Bowle	4	0	24	50	12·5
Harris	2	0	17	24	12
H. T. Palmer	2	0	22	22	11
T. Edey	4	2	17	21	10·5
E. A. Collins	6	1	16	27	5·4
H. R. Grellet	3	1	5*	5	2·5
E. W. Strange	2	1	0	0	0
A. H. Turner	1	0	0	0	0

* Not out.

BOWLING.

	Wickets.	Runs.	Average
R. C. Poyser	14	163	11·64
T. Edey	19	250	13·15
F. C. Wetherell	11	160	14·54
K. V. Trubshaw	18	321	17·83
C. M. Cowper	17	350	20·59
M. C. Wetherell	22	460	20·90
(Less than 10 wickets).			
W. Morgan	2	2	1
S. C. Bowle	1	2	2
E. W. Strange	1	20	20
Harris	5	117	23·4
F. Morres	3	92	30·66
J. M. Brydone	1	37	37
J. T. Hicks	1	38	38

From the Gazette's Special Pathologist.

NOTICES.

X. Y. Z., Hastings.—Tubercle bacilli were found in the sputum in considerable numbers.

W. R., MAIDEN NEWTON.—The growth in the lip and cheek is a melanotic sarcoma, composed of oval and fusiform pigmented cells. It has already invaded the muscular substance of the lip.

PATHOLOGIST.

Birth.

BUTLER.—On August 20th, at "Trevose," 229, Beckenham Road, S.E., the wife of Arthur G. Butler, M.B. Lond., L.R.C.P., M.R.C.S. Eng., of a son.

Marriages.

LEVICK—ASHWIN.—On Thursday, August 23rd, at the Parish Church of St. Margaret's, Quadring, by the Rev. Forster Ashwin, Vicar of Quadring, Lincs., George Kenny Levick, M.B., B.S. Lond., of Havant, to Florence Isabel Ashwin, daughter of the Vicar of Quadring.

TURNER—DALBY.—On August 23rd, at St. Matthew's, Ealing, by the Rev. F. Dalby, Vicar of Holy Trinity, Gainsborough, cousin of the bride, assisted by the Rev. H. C. Douglas, Vicar, Frank Douglas Turner, M.B., of New North Road, Huddersfield, to Louisa Caroline (Midgie), youngest daughter of Major Dalby, R.M.L.I., of Tregoe, Ealing.

ED.—S. H.

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Calendar of Coming Events.

September, 1900.

Sat. 15.—Messrs. Jacobson and Fripp's take-in; Drs., C. Tessier and G. T. Collins; Cl., D. Forsyth.

Hos.-Scho. C.C., L.B.&S.C.R. Electric C.C., away.

Mon. 17.—Third and Final M.B. Durham Exams. begin. Last day for sending in Fees and Certificates for Camb. D.P.H. Exam.

Tues. 18.—Schedules for Final Conjoint Exam. to be left at the Medical School Office not later than this date.

Thur. 20.—Messrs. Howse and Symonds' take-in; Drs., E. Bigg and S. Child; Cl., T. E. Holmes.

Sat. 22.—Last day for applying to Registrar for Form of Entry for Final M.B. Lond.

Tues. 25.—Exam. for Entrance Scholarship begins.

Thur. 27.—Messrs. Lucas and Lane's take-in; Drs., G. Evans and R. C. Lawry; Cl., T. J. Wright.

Sat. 29.—Students' Special Number of the GAZETTE published.

Guy's Hospital Gazette,

SEPTEMBER 15, 1900.

The Treatment of Diseases of the Heart,

II.

CLINICAL LECTURE BY DR. HALE WHITE.

June 13th, 1900.

GENTLEMEN,—We will to-day continue the subject of the treatment of heart disease (see GUY'S GAZETTE, August 11th, 1900). Just to refresh your memory I may mention that we have two cases now in Clinical which illustrate very well some of the points that we talked about. For instance, there is a man in No. 2 bed in John with marked aortic disease. After the lecture last time one of you asked me whether he should have digitalis. With regard to that point you must decide each case on its merits for yourselves, which will not be difficult if you will just think out what you want the drug to do. If you have a patient with aortic disease whose pulse is abnormally rapid, it may be wise to give him digitalis; but, generally speaking, the pulse in aortic disease should not be slowed by digitalis, for that retards the pulse by prolonging the diastole, and the longer the diastole the longer the time there will be for the blood to regurgitate, if there is regurgitant aortic disease, so that you may render people with aortic incompetence liable to syncope if you give digitalis.

Again, it is an obvious fact in aortic obstructive disease that the heart is usually greatly hypertrophied; the weight of the hypertrophied heart is sometimes enormous. I have made a post-mortem in which the heart weighed forty-three ounces. That is quite exceptional, but in the generality of cases the heart is very much hypertrophied, and you do not want to increase the force of a heart in that condition. But if in cases of aortic disease you think you can, without dangerously prolonging the diastole, derive benefit from slowing the pulse, give digitalis, and if you think the heart is not acting with sufficient force, and you want to increase its force, give digitalis. Then, too, the administration of digitalis may be determined by the irregularity of the heart. You see, the question that teachers are often asked, "Whether you should give digitalis in aortic disease" is not a good question to ask, because there is no hard and fast rule. I do not know any department of medicine in which more mistakes are made than in the treatment of heart disease, those mistakes resulting from the vague notion which many men have that digitalis is good for such cases. You must try to get deeper and think out what you want to do with the drug, and then decide whether you should give it.

Next, there is a woman in the corresponding bed in Miriam who illustrates one of the points of the last lecture. She was given digitalis when she came in, and it made her sick, and you remember how extremely bad we found sickness to be for sufferers from valvular disease. Perhaps we shall give it to her per rectum if we find she really needs it.

Last time, as I have said, we were brought to the point of talking about digitalis, and the next heading under which we will discuss the treatment of heart disease is that of the discomfort, oppression and disagreeable feeling of dyspnœa

of which patients with heart disease often complain. These feelings are strikingly illustrated in the case of the man in No. 2 bed in John. You can frequently do a great deal of good for those who suffer in this way, and I think that for this feeling of oppression and weight at the chest, and general unrest and restless look, often especially marked in sufferers from aortic disease, the best thing is to begin by trying nitrites. I remember cases in which we have let the patient inhale some nitrite of amyl, and so instantaneous has been the benefit to the breathing that you would hardly have thought the drug could produce its effect so quickly. It certainly benefited No. 2 John. But in a bad case, like No. 2, nitrites often fail after a time, and only yesterday when I saw No. 2 he was not permanently much better, and so we gave him some nitro-glycerin. We shall see to-day if that has done him any good, and if not the next best thing is to give these patients iodide of potassium. Often that does all that is possible, but how it acts I do not know. I hardly think it can be because in some of the cases the aortic disease is syphilitic.

If these drugs fail we might try local applications, such as leeches, or a belladonna plaster over the heart. Leeches, although useful for cardiac pain, are most useful for the hepatic pain met with in sufferers from heart disease who have a large tender liver, as you remember I told you last time. The woman in Miriam came in with an enormously big liver, and so tender that she would hardly let you touch the skin over it. She complained of intense pain and so we placed leeches over it and soon the pain and tenderness were completely gone. How the leeches act no one knows. It is not obvious that putting them on the skin in any way withdraws blood from a deep-seated organ like the liver, but this treatment with leeches is, nevertheless, very useful indeed for the pain of heart disease, and particularly for the pain which these patients get with a big, swollen, tender liver. Very often, as in this case, a dose of calomel markedly helps to relieve the hepatic pain. Although the remedies I have indicated alleviated this woman's pain, distress and discomfort, they did not completely remove them. Therefore we gave her some morphine, to her very great relief. I am quite sure that many of you are inclined to withhold morphine too much in heart disease. Personally I should say that a by no means uncommon error in the treatment of heart disease is giving too much digitalis and not enough opium.

For dyspnœa the inhalation of oxygen is useful. But there are two kinds dyspnœa in heart disease: there is dyspnœa associated with lividity from backward pressure, and separate from this, or in addition to it, there is pure cardiac dyspnœa, for which we have no entirely satisfactory explanation. You see a pale man sitting propped up in bed; he dare not lie down he is so short of breath, and for that class of case you will not find oxygen so useful as for the livid class.

Talking of No. 2 in John reminds me that students often make the mistake of thinking that faintness is a frequent symptom of heart disease. If patients faint the chances are that they have nothing organic the matter with the heart, so that in cardiac disease you do not often have to treat faintness. As a rule, patients who faint are anæmic people, not people with organic disease of the heart. If a patient with disease of the heart should faint, treat him on ordinary principles, make him lie down, let him inhale a little ammonia, and give him some brandy.

Another point which the cases in the wards bring before us is the treatment of cardiac hæmoptysis. Hæmoptysis means that there is backward pressure in the pulmonary veins, and that the right side of the heart is over-distended with blood that cannot get on through the pulmonary artery. The bleeding is beneficial. In the case of a woman in Mary, this beneficial effect is very striking. Also not long ago there was the case of a washerwoman suffering from heart disease who brought up some blood about once a fortnight, and always felt the better for it, and no doubt it was an excellent natural means of getting rid of the blood which was over-filling the right auricle and ventricle.

These are the points which I want to bring before you with regard to the cases of heart disease now in the hospital. Let us now continue our discussion of the treatment of heart disease generally. I think you ought in practice to divide your cases of heart disease into two groups: those that are so bad that they must give up their work and rest in bed for a time; and the other and much larger group is the group that can get on and do at least some of their work if you will only give them proper directions.

For the remainder of the time to-day I want to discuss the treatment of the second group. The most important thing, undoubtedly, is the right balance in these people of rest and exercise. Forty years ago it was considered that nearly all people with heart disease should rest. You know perfectly well that if you overrest a muscle you do it harm. It becomes weak

and atrophies. The same may happen to the heart if the patient remains too long in bed, and while too much exercise will be harmful, many cases of heart disease can do very well for years if the amount of work done by the heart is properly adjusted. It is only within the last thirty or forty years that the profession has learnt this, and formerly the prognosis of heart disease was often much too grave. I have frequently told you the tale told by Sir Andrew Clark, of the chaplain of a hospital. A short time after murmurs were first discovered, one of the physicians of the hospital heard a murmur in the chaplain's chest, and he told the Governors that the man had serious heart disease. "Well," said the Governors, "can he live long with it?" "No, he cannot possibly live with such heart disease!" "Oh, well, in a case like that we will pension him off at his full salary," and the chaplain retired and lived at his ease, and enjoyed a very comfortable life for many years, drawing his full salary the whole time. Then, again, the oldest physician that I know—I think he is almost the oldest physician in the profession, being now ninety years of age—has had a murmur for very many years, and yet remains in good health. So that you see you can clearly over-rest some sufferers from heart disease; because, supposing this physician had retired to bed when the murmur was first heard, say, at forty years of age, the unfortunate man would have spent the last fifty years of his life in bed, if he had lived to his present age.

For every living heart, whether diseased or healthy, there is a certain amount of work it can perform. If called upon to do more it fails. This is seen in healthy hearts in the dilatation that follows excessive muscular exercise, and is constantly seen in diseased hearts. If called upon to do less than this certain amount of work the heart loses strength and becomes feeble.

I do not know anything that will tax your judgment more than deciding for every patient with heart disease precisely how much he ought to do and how little he ought to do. It will show just the difference between a doctor who has some common sense and one who has not. There are a few things in everyday life that are particularly bad for patients with disease of the heart, because these things bring a great strain on it. One, for instance, is going upstairs. If you find that a patient bears the stairs badly, tell him to go and live in a house where his bedroom is on the ground-floor. It has been calculated that raising the body to a distance of one foot perpendicularly requires as much effort as walking twenty feet along the level, so that, as you can imagine, the act of going upstairs often must involve a very considerable strain upon a person suffering from heart disease. Only on Saturday I saw a child, ten years of age, with some form of congenital heart disease, and that child was perfectly well if she spent all her day on the same floor, but if she went up to her bedroom, for half an hour afterwards she was short of breath, and many attempts to come upstairs would inevitably have led to dilatation of the heart.

Even the kind of country in which these patients live is of importance. I have watched for years the case of a governess with well-marked mitral regurgitation. She is fairly well if she takes a situation where country is perfectly level. But she took a situation in a hilly country where her work could not be done without going uphill with the children, and as a result her heart gave way so that she had to give up the situation.

And then, too, you must give specific directions to people with heart disease about the kind of exercise they ought to take. That perhaps comes before you especially prominently in the case of children with congenital heart disease. It is so obvious that it is hardly worth mentioning to you that certain games cannot be played by people suffering from heart disease. Clearly football should not be played; obviously, too, severe lawn tennis or rowing must put a very great strain upon the heart, and what is particularly bad in such games is that the strain is sudden. On the other hand, a game like croquet, or a little golf, or a little fishing without a heavy rod—these are things many sufferers from heart disease can do, and these are the games to which you must accustom a child with congenital heart disease, and you must be absolutely strict and certain in the directions that you lay down. Do not think that I exaggerate the importance of what I have just said. It does not matter much for most people whether they get overtired or not, but you must remember that a single game of football, or a single hard row may bring the apex out an inch if there is organic disease of the heart. That means dilatation, and that is bad, so that you will have to lay down precisely what may be done and what may not be done, and go through all the sports there are and say "Yes" or "No" to each one of them if you want to do your duty to the patient. Bicycling is a thing that you will always be asked about. Often if the patients will go gently on the level and at moderate

speed, there is no particular harm; but just think of the extra strain that is necessary to raise yourself and bicycle up a hill. It does not require a moment's thought to see that doing such a thing must be very bad indeed in many a case of heart disease.

Then again, if a patient is new to you, insist that you will not undertake the case unless you may see the patient from time to time. You should tell such patients, "You won't get on unless you go back to your doctor and let him see you once a week, a fortnight, or a month," (according to the gravity of the case), so that he may examine the heart and the position of the apex and see for himself whether you are doing more than you should." Obviously the right thing is for the patient to take as much exercise as he can without doing himself harm, and at the end of six months or a year patient and doctor will have learned what is the maximum of exercise allowable.

These people with heart disease might be looked upon as a different sub-division from the rest of mankind, and characterised by having a mind to do the same amount of work as those of us whose hearts are healthy, but physically being unable, they must learn for themselves and limit their energies to the level of which they are capable.

Two special treatments have been devised for these cases. In each the object is the same, namely, to precisely regulate the amount of exercise taken by the patient. One is the Oertel treatment, and the other the Nauheim treatment. As you may be asked about these in practice, it will not be waste of time, I think, to tell you something about them. Oertel was a Munich physician, and his mode of treating heart disease became particularly well known, because Schweniger, who was Bismarck's physician, took it up very generally, and hence it is often known as the Schweniger-Kur. Oertel's treatment was originally applied to people who were too fat, and he rightly said, "These people are too fat; I can reduce their weight. There are three ways of reducing it. I will make them sweat a great deal, and diminish their food, and regulate their exercise" —all of which was very good. Gradually the treatment extended from the group of people who had over-eaten themselves, and it dealt also with sufferers from heart disease, and, applied to them, it consisted in this—sufferers from heart disease went to various towns, chiefly in the different forests, such as the Black Forest, and their walks were graduated by the physician. If the case were very bad the patient had to walk so many yards along the level and then sit down; if not so bad he had to walk a little farther; if the case were still less marked he was allowed to ascend a gentle hill, and the doctor always chose such a neighbourhood as presented various gradients easy of access for the patient. Seats were scattered about so that he could sit down and rest when needful, and he was examined from time to time to see that the exercise had not been excessive.

There is nothing special in this treatment. The principle of it is just what I have been telling you, namely, that you must graduate the exercise. The only special benefit of it is that people are often very foolish at home, but if you send them away to some place with the special object of treating their disease they get impressed with the importance of doing as they are told. But if your patients will obey you at home there is not the slightest need to send them to any particular place to undergo this treatment.

Another means of treatment in these cases was developed by the brothers Schott. It is really only a form of taking exercise and may be summed up in this—that the patient resists certain movements. For instance, he is directed to bend his arm up slowly, someone meantime resisting the movement, and the sufferer from heart disease is made to do more or less work, according to the force employed by the person who is resisting his movement. The performer, standing near the patient, usually begins with the arm, and the patient is made to do an upward movement, the performer resisting it. Then the arm is brought down again, and again this movement is resisted. The same is done from the shoulder, and the wrist, and the hand. And then the body is bent forward and backward against resistance, and so also the leg. In all there are thirty or forty movements which the patients able to take a full course are made to resist. You see there is nothing special in this. It is only a question of graduated exercise such as I have been insisting upon for the last few minutes. The advantage of it is that you can graduate the exercise according to the physical strength of the patient, but there is no reason for supposing that it is superior to any other form of exercise provided that—and this proviso is very important—the exercise is so graduated as to be just enough, but not too much for the patient. The Schott movements, as they are called, are thus simply a means by which you can give your patient with heart disease just enough exercise to keep his body in health, and not enough exercise to dilate the

heart; nurses are given a series of directions which they have to observe in order not to let the patient take too much exercise in this way. They are usually told that the movements must be performed slowly and at a uniform rate; that they should not work the same group of muscles twice in succession; that the patient should always rest between each movement; that they must give up at once if the patient becomes short of breath, as shown by dilatation of the nose, compression of the mouth, sweating, palpitation and so forth; that the patient must be kept quiet; and that he must not be put in any uncomfortable position, such as the head lower than the limbs.

Patients who go to Nauheim, in addition to being made to go through the exercises, take baths. There are plain salt baths at a temperature of about 85° or 90° F. All of us take our bath every morning, and there is no doubt whatever that baths, especially baths containing common salt, are good things. Everyone knows that a swim in the sea braces him. That is common knowledge, and there is no special effect produced by these baths administered to these patients. They are usually put into a salt bath for five or ten minutes, at a temperature of 85° to 90°, and they feel the better for it, just the same as you would feel better for ten minutes in the sea. It is refreshing and invigorating, and helps their circulation and does them good. There is an almost inconceivable amount of nonsense and quackery written about these baths. For instance, diagrams have been published showing that when a man went into a bath his cardiac dulness was well outside the nipple line, and when he came out it was well inside the nipple line. According to diagrams published, the diameter of cardiac dulness will sometimes in the bath diminish in the ratio of 6 to 4, and the inference is drawn that this is due to a diminution of the size of the heart. To show you how absurd this is, you only have to remember that if you have a sphere with a diameter of six inches and diminish it to four inches, you diminish the contents of that sphere by three-quarters. So that, if the diameter of the cardiac dulness diminished from six to four, and this were taken to indicate a proportionate decrease in the size of the heart it would mean that the cubic contents of the heart were somewhere about three-quarters less when the patient came out of the bath than when he went in. This is obviously ridiculous, and shows that we must not take a diminution of the cardiac dulness as indicating a corresponding diminution of cardiac size. Probably when a bath leads to great diminution of the cardiac dulness, it is because the edges of the lungs are better inflated, and so more of the heart is covered by them.

But that baths help the circulation has been clearly demonstrated by some experiments which were published in the *Journal of Physiology* by Leonard Hill. He took a chloralised rabbit and held it up by its ears so that the legs hung down. If left in that position under the influence of the chloral, its circulation and its breathing became feeble, and it very soon died. In that particular animal which is created to run on all fours, the erect position, especially under the influence of chloral, quickly produced fatal syncope. But, if when the rabbit was almost dead, the lower part of its body was dropped into a pail of water, the creature at once revived. The experiment went to show that the extra pressure of the water on the abdomen prevented that great fall of blood into the abdominal cavity which occurs when the creature is held up in the vertical position, so that the blood dropped down into the abdominal cavity. I mention this because it is interesting as showing that there may be an actual physical explanation for the benefit of a bath in heart disease. The experiment suggests that one reason why getting into a bath helps the circulation, is because the extra pressure of the water drives the blood out of what, as you know, is, so to speak, the great reservoir of the circulation, namely, the abdominal vessels. Certainly some patients with heart disease often feel better, and have a better pulse after a bath.

You may be inclined, after what I have said, to think that the treatment by baths and graduated exercises is of very little use. Often such treatment is not only useless, but positively harmful, as for instance in the cases we were discussing in the last lecture, but if you will select your cases with judgment, you may often do good by graduated exercises, with or without baths. I should advise you to most willingly let your patients go through the treatment just in proportion, as there is nothing very serious the matter. If there is grave organic heart disease, the exercises and the baths will be too exhausting, also the journey to Nauheim, and living in a strange hotel without home comforts will be very pernicious. But, on the other hand, cases in which the valvular lesion impairs the heart but little, are often benefited by the treatment carried out either at home or abroad. Perhaps the patient for whom the treatment does most is the timid person with no organic mischief, and who comes

to you and says, "I know I have heart disease, do not you think that I should go under that special treatment?"

Another thing. Those people who are able to get about well, and are known to be sufferers from heart disease, will often come to you and ask what should be their general rule of life. Often even you have to determine what profession young people with heart disease should choose. Clearly that is a matter of common sense, and one which you will have to spend half an hour discussing with the parents of the boy who is about to enter some profession. There are two or three things which you ought particularly to warn them against. Obviously, excess of alcohol is bad; it quickens the pulse, makes the heart more rapid, and it is undoubtedly a bad thing for patients who have heart disease to drink much. In the same way everyone knows that some healthy people can often stand a large amount of tobacco, its only momentary discomfort perhaps being that much tobacco makes the pulse intermittent, but obviously that is bad for patients with heart disease. So that people with heart disease, if they smoke, should do so only in moderation. The same applies to diet. The abdominal vessels will dilate and the whole circulation be upset if a man puts a huge meal into his stomach. If, on the other hand, he takes several small meals during the day, and never over-loads the stomach, he will stand a much better chance of getting on well. So that in everything, whether it is work, or exercise, or alcohol, or tobacco, or diet, the thing which I want you particularly to remember is this: what is required is moderation in everything, and you must find for every patient the exact limit of what he can do to keep his heart in the best tone possible, and insist that he does neither more or less for the remainder of his life.

There is one other point to which I should like to refer, and that is, the question of pregnancy. There was a woman in Mary some year or two ago, suffering from mitral disease, who was confined at the seventh month, and the report says that she nearly lost her life. She became extremely livid and dyspnœic. She became pregnant again, and she was admitted to the hospital at about the seventh month; we thought that by resting her she might be able to go the full time, and so she did. All the while during the seventh, eighth, and ninth months of pregnancy she seemed to be doing very well, and she was transferred to Queen ward for delivery to take place, and I was told that then too she had very nearly died. Quite recently I saw a patient suffering from mitral disease that was, before confinement, producing no backward signs; she was confined at the ninth month. A few hours after she became livid and almost pulseless, and when I saw her twenty hours after her confinement she had a dilated right side and was moribund.

These cases illustrate admirably, and will serve to impress upon you, how careful you must be when you are consulted as to whether women suffering from heart disease should marry. You will require much judgment to estimate whether it is likely that a particular heart will be able to stand the strain of pregnancy, for although I have known even repeated pregnancies have no apparent ill effect on a diseased heart,—for example, I know the case of a patient who has had a murmur indicating mitral regurgitation for years,—she has had three children, all the pregnancies have been perfectly simple and the confinements have been natural. Yet, on the other hand, you will meet women suffering from heart-disease who are killed, or nearly killed, by pregnancy. No good would be done by my trying to lay down any general rules; each case must be judged on its own merits, and you must fully explain to women suffering from heart disease the risk they run in becoming pregnant.

The last thing to which I want to direct your attention is the proper treatment of those numerous cases in which, while a patient with rheumatic fever lies in bed, a murmur developes or the apex beat of the heart shifts out a little. There is a strong probability that in many cases of rheumatic fever the myocardium is inflamed, and also that the valves may be affected with endocarditis so slightly as, at first, to produce no murmur; hence, if you let patients with rheumatic fever get up too soon—especially if a murmur is present or the apex displaced—you run great risk of cardiac dilatation which might have been prevented if the patient had been allowed to rest until the endocarditis or myocarditis had recovered. Far too many patients with rheumatic fever are allowed up too soon, and hence they suffer from cardiac incompetence for the rest of their lives. A month or six weeks after the temperature is normal is often none too long for a convalescent from rheumatic fever to remain in bed.

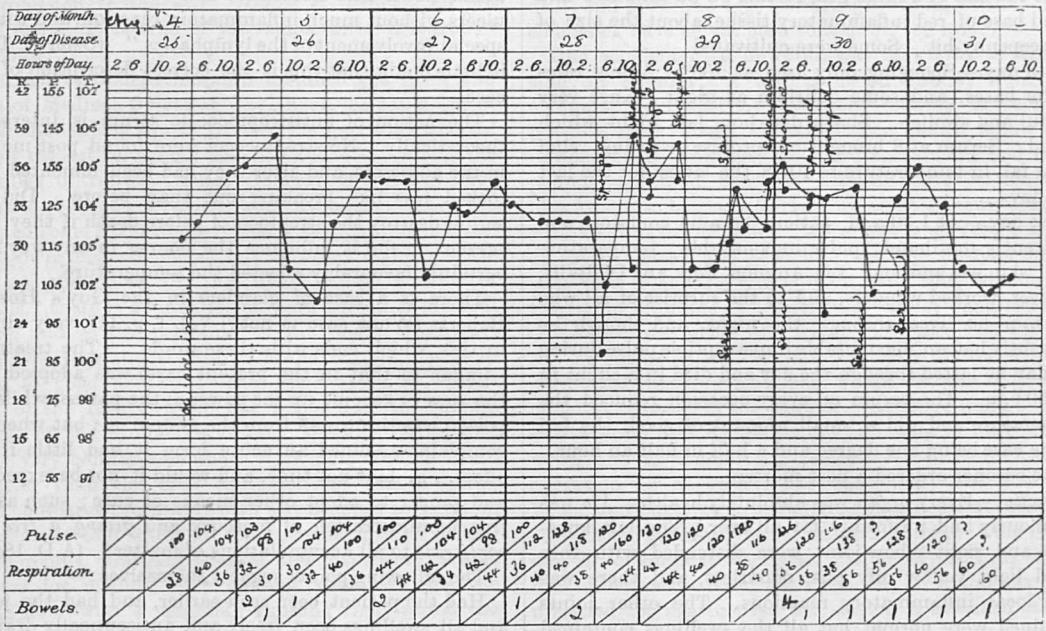
To sum up what I have been trying to make clear to you is that the whole art of treating the class of cardiac cases that we have been considering to-day lies in correctly estimating the amount of work you may call upon the heart to do. If you do this successfully, patients with

good compensation may, without any aid from drugs or medical treatment, live and carry on their occupations successfully for the same period as most of us.

A Case of Glanders in a Man.

Cases of glanders verified by post-mortem and bacteriological test are interesting from their rarity and from the difficulty of treatment.

The following case presented so much difficulty clinically, and so little difficulty pathologically, that some remarks on these two aspects may be interesting, always premising that "it is easy to be wise after the event."



W. M., æt. 45, a livery-stable keeper, married three times, ten children, only one living, no medical history, was admitted into John on August 4th, 1900. The general practitioner called in Dr. Bryant, who, from his condition and surroundings, advised his removal to a hospital with the diagnosis of "glanders."

There was a fairly definite history of "horse-sickness." but no direct history of contagion.

"*Condition on admission.*—A huge healthy man of 46, looking a little alcoholic and well nourished. He is tremulous and very frightened, his hands shake violently, his *mind is quite clear*, and he is obviously ill.

"Temperature, 103·2°; pulse, 100; respiration, 28. His cheeks are flushed, his skin is hot, his temperature apparently does *not distress* him at all. Breathing regular, no râles, heart normal, no headache, no diarrhœa.

"There is a sinus discharging, *without inflammation around*, thin, watery, light yellow pus on his left forearm (flexor aspect). There is a *subacute* inflammatory swelling over his right elbow externally, and the backs of his first and second metacarpals. There is a similar swelling over the aspect of his left knee. All these swellings look like *deep-seated pus* slowly coming to the surface. General condition good."

Urine 1020, acid, urates. Liver palpable, spleen not. Bowels open. Abdomen normally large.

He was taken ill twenty-five days before admission with pains in the arm which were called *rheumatic* and treated. *An abscess* subsequently appeared, which was opened. He continued to have a temperature ranging from 103°–104° till admission.

Treatment was that of toxæmia from a local focus, *e.g.*, supporting and stimulative with attempts to destroy the source of the toxæmia. Hyd. perchlor. fomentations were given p.a. 4tis horis. Full diet with port and iron, nux vomica and quinine, 6tis horis.

26th day.—Patient slept well. Temperature 105·6°; pulse 104; respiration 36. No distress. The temperature dropped to 101·6° at 2 p.m., and rose to 104° at night. He feels and looks better.

27th day.—It was decided not to open the swellings, as it was thought no pus would be obtained, and Mr. Pakes did not think a cultivation would be successful.

28th day.—Slightly better, but was a little delirious last night. Sleeps well as a whole, and takes food well. Knee more painful. Dr. Fawcett saw the patient and thought the swellings might be erythema nodosum, and ordered salicylates and caffeine, and milk diet. Patient was sick after the medicine, and got rapidly worse. His pulse rose to 128, and he was blue and dyspnœic. He was at once given Liq. Ammon. Fort. and Digitalis, which revived him. Dr. Fawcett advised replacing him on

Quinine and Nux Vomica, and thought the attack might be due to cardiac spasm.

His temperature at 10 p.m. was 105·8°.

It was thought that the trouble might be streptococcal, and by Mr. Pakes' advice several kinds of sera were ordered to be tried. He was delirious, and much worse all night. Aspiration of the knee was suggested, but not done.

29th day.—He was rather better to-day in his general health, but his temperature is usually above 104, and he is consequently frequently (and unsuccessfully) sponged. The serum was tried to-day and apparently is of service. There is a crop of fresh swellings on his back and his thighs and left arm of red shotty papules, becoming rapidly vesicular, and finally developing into pustules about the size of a large pea, resting on an inflamed and raised base of red inflammatory tissue, about the size of a threepenny-bit. Some were cultivated.

30th day.—Sponging only used at 105°. A few râles at the bases, and some delirium at night. Knee very painful and swollen. Sharp diarrhœa last night which ceased. Serum at 8 brought out profuse sweating, relief and a fall in temperature to 101·8, the lowest for the last four days.

31st day.—At 1.30 a.m. patient became comatose and apparently moribund; pulse uncountable; temperature 105°; skin wet and cold. Lig. Ammon. Fort. and Digitalis, however, worked wonders, and to the surprise of all who saw him he lived through the night, and though he frequently had an uncountable imperceptible pulse during the day he lasted through the day and died in a slight fit at 6.50 p.m. The serum on every occasion reduced the temperature and did a small amount of good, the fall in one case being one degree and a half in half an hour.

The coroner ordered a post-mortem.

Briefly.—Every organ was absolutely healthy. He was enormously and uniformly fat all over. The left knee-joint and right elbow-joint were distended with thin liquid light yellow oily pus, odourless, and there was little local inflammatory reactions. The other joints examined were normal, but all the swellings contained the same. There were five ulcers, recent and inflammatory, in the intestine, two in the small and three in the large. They were superficial and recent. The respiratory passages and brain were normal. Cultures were taken from the pus and the blood. All the cultures taken post-mortem were too weak and mixed to give any result; but a cultivation taken from a pustule before death produced a brown growth on a potato which, though thought to be dead, yielded eventually about a month later a pure culture. This, on inoculation, produced orchitis from which a pure culture was reproduced.

A few points are worth noticing as bearing on the diagnosis.

1. The history and duration of the case. A case has been quoted of death from glanders in a city clerk. The usual course for fatal cases is about four weeks.

2. The temperature was very high and the pulse and respirations low (c.f. enterica), and he never had a rigor, no headache, and no delirium till the end.

3. There was no enlargement of the glands.

It was obviously not acute glanders with implication of the mucous membranes, but if glanders at all, the chronic farcy form, of which about half the cases recover.

The interesting points are that it is usually taken for rheumatism in its early stages (vide supra), or if not diagnosed as farcy it is held to be a chronic pyæmia.

Reviewing the case from the superior standpoint of knowledge, it is obvious that the reasons urged against pyæmia were valid, *e.g.*, absence of *rigors* or delirium, the absence of distress or of *acute* local foci of suppuration, the absence of glandular enlargement, headache, and pathologically the non-implication of the lung.

"Chronic farcy is characterised by the presence of localized tumours, usually in the extremities. The tumours break down into abscesses, and sometimes form deep ulcers without much inflammatory reaction, and without special involvement of the lymphatics." (Osler.) There is little doubt that this is the correct description of this case.

The action of antistreptococcic serum is interesting theoretically. No streptococci were found post-mortem in the abscesses, and after they had been fomented they looked less like breaking out than before. Did the serum destroy the streptococci before death if they were present, or did it influence the course in any way? It certainly favourably affected the temperature.

There is a case of glanders in the Guy's Hospital Reports (What case is not?) Vol. I. p. 117, very similar to this, which ends with these words. "The treatment (similar to that in the present case) was adopted with the view of keeping up the power of the patient while the poison was thrown off from the system . . . but when the complaint assumed an acute form it had little if any effect. . . . Is it not time, and would it not be expedient and proper to adopt other means of cure; such as the free administration of mercury and *giving a free and early exit* to all accumulations of matter? (A.D. 1843)."

The following points suggest themselves:—

Had the patient been seen earlier, and had the joints and all swellings been freely and antiseptically drained, would the toxæmia have been less, and would the patient have survived?

Has the injection of mallein which has been reported to be efficacious in curing animals, and has never yet been tried in man, any place in the future?

Is the temperature caused by a pure glanders infection normally between 101° and 103·5°, and the hyperpyrexia due to associated streptococci or other pyogenic bacilli? The administration of serum apparently tended to reduction of the temperature, and the pus was certainly sterile as regards ordinary pyogenic organisms.

Practically the treatment outlined half a century ago is substantially the same at the present day.

The County Council veterinary inspector was confident it was not a case of glanders, and at the examination of the horses only six appeared suspicious out of 150, and the mallein reactions were rather dubious.

J. M. BRYDONE.

With the Army Medical Corps in South Africa.

(BY OUR SPECIAL CORRESPONDENT.)

(Published by permission of the Director-General of the Army Medical Service).

Wolvehock Station, O.R.C.,
Wednesday, July 4th.

I regret to hear of the death, at Bloemfontein, from enteric fever, of Mr. Thomas Bryant's son, an old Guy's man and a civil surgeon, who joined No. 9 General Hospital at Bloemfontein early in April. The tale, I fear, is not yet told of vigorous, promising lives subscribed by our profession to the war. *Dulce et decorum est pro patria mori.* It is true of the combatant: it is true of the doctor.

Your correspondent has now assumed the titles and duties of Medical Officer of Wolvehock, Taibosch Spruit and Kromellenborg Spruit Camps, the garrisons whereof number respectively about 250, 650 and 450. Along the 130 miles of railway under General Smith-Dorrien's command between Pretoria and Kroonstad there are stationed some 8,000 troops. Each regiment, of course, has its own medical officer, but as many regiments are split up and most of the little camps consist of "details," there is abundance of work for other medical officers, and so the personnel of the Bearer Company, which was lying almost idle at Elandsfontein, has been turned to good account. The Field Hospital, meanwhile, of the 19th Brigade has taken over the private hospital of the Simmer and Jack Mine in Germiston, and is very comfortable there. In fact, nothing could be better than the civil equipment of this hospital, which compares favourably with any hospital in London. It consists of four wards for ten cases each, with several private rooms, first-rate theatre and dispensary, ample quarters for medical and nursing staffs, all on the ground floor, with a verandah running right round the house, and a large garden with a tennis-court for the resident medical officer. This officer has a private house and grounds allotted to him, a salary which in London would be considered ample, has but little obligatory work to do, and has abundant opportunities of private practice as well. In fact, several medical men manage to be appointed to two or three, or even ten mines each, and with this as a nucleus, together with private practice and many good hints and opportunities for lucrative investments, they are soon able to make their fortunes and return home in comparative wealth. Consequently, as the English population is sure to increase rapidly after the war, and new towns are constantly springing into life, newly-qualified men with their heads on their shoulders and £100 in their pockets may be well advised to come out here in a year or two's time. They would thus have the satisfaction, if worthy of their salt, of promoting the ideals of Imperial Citizenship.

The centres of medical work along this line of railway are the Simmer and Jack Mine at Germiston—the town of which Elandsfontein is the railway junction—and the hospitals at Kroonstad and Pretoria. All the seriously sick along the line are supposed to be sent to one of these centres. But as the trains are running very irregularly, as there is often no covered truck available, and as no medical officer can be spared to accompany them on their journey, the serious cases are not infrequently kept at the local stations. At Viljoen's Drift, the R.A.M.C. officer has made use of the civil doctor's offer of his private hospital, used especially for the employés of the two coal mines close by. And here two iron houses (most houses in this country being of iron) have been taken over for hospital use, two beds have been discovered, there is abundance of coal from the drift, and milk and eggs from neighbouring farms; and so no sick have as yet been sent down the line.

One accident case, however, was sent down to Kroonstad on Monday. A wire came on Sunday from the commanding officer at Taibosch, "Come as soon as possible, man broken his leg." The foolish fellow had jumped off a train carelessly and sustained a bad compound fracture of the leg. Nothing could be done for him except to bandage the legs up and tie them together with a splint in the camp. A train at length came along at seven o'clock and took him and the medical officer back to Wolvehock; and at eight, with the assistance of the Camp Adjutant as anæsthetist—under supervision—chloroform was given, the whole thing scrubbed up, and the leg put up as well as was possible with the sheet of perforated zinc, two foot long, which was the only form of splint sent out in the pannier. As there was no wood available for making splints, and no tools to make them with, and as hæmorrhage might set in and further operation be necessary, the man was sent down to Kroonstad next day in the charge of a hospital corporal, after being given an injection of morphia. This is the only bit of surgical work that has occurred here; but a fine railway store-room with benches all round has been prepared for use in case the station is attacked at any time; and it is used every morning as an out-patient room for the half-dozen or dozen cases attending.

The medical equipment of the station, which was never intended to be used as a hospital, consists of a sergeant and two men, two tents and two panniers, one containing dressings and the other a small supply of drugs, all under the care of the medical officer, who is responsible for having made as much use of the buildings here as possible rather than send cases down to Kroonstad. By a diligent use of the telegraph wire half a dozen beds, with bedding and a few necessary hospital appliances are being procured from the Ordnance-department at Bloemfontein; an officer is on his way up with scrubbing-brushes and soap, amongst other things; and before long the fever cases may hope, instead of lying on bare and dirty floors in empty rooms, to be resting in comfort. But by that time it is to be hoped that some regular arrangement may be made for at least a comfortable carriage,

if not a hospital train, to patrol the line and so enable the seriously sick to be sent to a fully-equipped hospital.

But it is surprising how well the fever cases do at present with simple rest and a milk diet. Even with very high temperatures and all the leading features of enteric, the course of the fever is usually only six or eight days, and recovery is complete within a fortnight. At present, the garrison is very healthy, the water supply, the sanitary arrangements, the climate, the food, are all good. But there is no saying what might become of the place with a permanent garrison when summer comes on again.

The other cases are chiefly diarrhœa and colic, dry pleurisy which disappears in a week, and "veld sores," which only require careful dressing.

The medical officer has been asked to see two cases in Kaffir kraals. One was in a kraal five miles west of Kromellerborg—*making a thirty-mile ride in all that* day. An old Kaffir man had been quarrelling with a Boer farmer near by and had hurt his arm. On examination, the humerus proved to be dislocated at the shoulder, and there appeared to be crepitus in the axilla. There were no signs of bruising (although black skin is very deceptive), so the injury was probably due to a fall. All attempts at reduction were in vain; there was no chloroform at hand; if there had been, it would probably have been unwise to use it; and consequently the arm was simply supported by a sheep's skin and bandaged to the side. At a second visit from the medical officer, armed with chloroform bottle and a farmer as interpreter, the old man raised himself on both elbows, although the injured arm was still dislocated, and said there was no pain now except at night. There was considerable latitude of movement in the shoulder, and the parts around were perfectly supple. The farmer strongly advised no further attempt at reduction, either with or without chloroform; and the patient seemed perfectly contented with a prescription of cold water sponging. But such treatment seriously injured one's surgical *amour propre*.

The other case was that of a poor Kaffir girl living a mile or two from here, who was picking mealies in the field when a stray shot passed through her neck. Medical advice was only sought after three weeks, when the wound was healed, but the right arm and leg remained paralysed. The bullet passed in about three inches to the left of the seventh cervical vertebra and out just behind the right sterno-mastoid at the same level. There was no pain, but there was some loss of sensation, weakness and some wasting of the leg, and complete paralysis and great wasting of the right arm. There must have been some spinal injury, but of what nature it is difficult to say. It was difficult also to prescribe, but some treatment was obviously required, and massage with mutton-fat was advised, the order being vigorously delivered and illustrated by the station-master's little boy of 10, acting as interpreter. However, the six Kaffir ladies of the house considered this insufficient without some direct application to the scars of the wound, and so a small pad of spongiopiline wrung out of boiling water was applied, to be changed every morning. This gave great satisfaction. It is easy to become a quack.

There is a witch-doctor near here, who must be cultivated. Although a Kaffir, he says his name is Dr. Clarke, and he is well known in London. His country seat is near Taibosch, Orange River Colony. One of his neighbours the other day was making soap. One of the little naked Kaffir boys swallowed a lot of soda that was being used in the process, and became violently ill with the stomach ache. The colonel in command was consulted, and prescribed strong salt and water. The ladies of the house, however, must needs consult Dr. Clarke. "Salt and water," says Dr Clarke, "stuff and nonsense. Smear his face over with fresh milk and he will soon be well." Meanwhile, however, *the salt and water had been given at home and had* taken the desired effect.

F. E. F.

Davies-Colley Memorial Fund.

LIST OF FURTHER SUBSCRIPTIONS.

	£	s.	d.
Amount already acknowledged	283	2	0
Dr. J. F. Goodhart	10	10	0
Dr. R. E. Williams	3	3	0
Henry Williams, Esq.	3	3	0
J. H. Targett, Esq., M.S.	2	2	0
H. Gunton Turner, Esq.	2	2	0
G. T. Willan, Esq.	2	2	0
Dr. H. Strachan	2	2	0
W. Le Feuvre, Esq.	2	0	0
G. Angus Hunt, Esq.	1	1	0
J. R. Steinhaeuser, Esq.	1	1	0
W. H. Lamb, Esq.	1	1	0
E. H. Williams, Esq., R.N.	1	1	0
H. P. O. Manning, Esq.	1	1	0
Dr. C. G. Roberts	1	1	0
Dr. Harry Cooper	1	1	0
A. Roper, Esq....	1	1	0
H. St. G. Hore, Esq., R.A.M.C.	1	1	0
A. H. Finch, Esq.	0	10	6
C. E. Winckworth, Esq.	0	10	6
G. E. Lockyer, Esq.	0	10	0
H. J. Holman, Esq.	0	5	0

THOS. G. STEVENS, Hon. Sec.

Pass List.

University of Durham. September, 1900.

FIRST EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE.

ELEMENTARY ANATOMY AND BIOLOGY, CHEMISTRY AND PHYSICS.

A. V. Maybury.

Passim.

WHEN the present war receives its due treatment at the hands of the historian (and that usually happens after the lapse of some hundred years), possibly an unbiassed and calmly judicial statement of the condition of the hospitals will be obtainable. At the present moment it is impossible to attempt to follow the multifarious correspondence in the daily press without being struck by the extraordinary amount of "personal element" that is allowed to intrude into the question. Given that a man has a bad time in a field hospital and he damns the whole organisation, unfortunately in public. But it is only rarely that the man who is satisfied troubles to contradict the wild statements of his less fortunate fellows. It is in this connection that a letter from Mr. C. B. Sells, of this hospital, published in the *Standard* of last Monday is of value. He speaks simply for himself and expresses his whole-hearted gratitude for the treatment that he received when warded with dysentery and again with typhoid. He finishes with, "Do not pass judgment too quickly, you people at home, and do not swallow as gospel all you hear of the terrible times spent by those who were sick. All acknowledge that there was suffering, but it was inevitable. When the truth is known, you will find the sufferings undergone by patients were due to the exigencies of the campaign, and not to any fault or neglect." This seems by far the most reasonable view to take.

WE have received a letter from a Mr. Sitolchandra Pál, L.M.S., of Calcutta, in which he asks us to publish, "for the interest of the public," a leaflet which he encloses. This leaflet is apparently pages three and four of some circular, and bears no press mark of any kind. It starts with, "The following golden rules should be carefully observed by the consumptives," and then follow thirty-nine examples of crystallized genius. Space will not permit us to publish the whole of this extraordinary production, but a few selections from the golden rules will suffice to suggest the nature of the rest. "Wear underclothing and all other clothing adapted to the season of the year." "Keep one window open in your sleeping room always on the other side of the bed." "Dr. S. C. Paul's Phthisis Inhalation should be freely used no sooner the disease is detected or suspected." "If indulge in reading, always read aloud." "Too much medication is rather injurious." Apparently the key to the whole thing lies in the advice to use "Dr. S. C. Paul's Inhalation"—his address is given in the page of golden rules. The semblance between Sitolchandra Pál and S. C. Paul is too obvious to need comment.

THE prospectus of the Brinklea Sanatorium for the open air treatment of consumption has just reached us. Bournemouth with its warm sun, sea breezes, and pines, is pretty generally accepted as one of the most favourable sites for the residence of consumptives, and therefore an excellent situation for the exercise of the "new treatment." Dr. Kinsey-Morgan, the medical superintendent of the Sanatorium has adopted the principles of treatment first taught by Brehmer, at Goörbersdorf, and then carried out with great success by Dr. Walther, of Nordrach. Judging by the photographs which are included in the prospectus, the grounds are eminently suited to their purpose, and are well fitted with shelters and sleeping huts for the more robust patients. The fact that an extension to accommodate thirty-five additional persons is in course of construction is sufficient evidence of the recognised value of this institution.

IN the *Sporting Times* appears a very old friend dressed in a new garb and fathered on us.

Saturday night in the out-patient department of Guy's.

A constable has just brought in a very dilapidated case for diagnosis—query apoplexy, query booze?

Patient settles the difficulty by suddenly attempting to swim across the floor, muttering the while:—

"Never mind me, Keptin, shave the women and children first."

We had always imagined him to be a Cambridge undergraduate after a bump supper.

No step as yet has been taken in the matter of a memorial to the men who fell in Africa. The objection that the war is not over, and that therefore the casualties are as yet undetermined, can hardly have any weight if we consider the very long time a project of this nature takes in its unfolding. Much time is sure to be devoted in preliminaries, and the exact nature of the memorial will take some settling. When the idea was first promulgated, we were inclined to think that a stained glass window in the Chapel would be the best. On enquiry, however, it

appears that the general idea is opposed to this, chiefly because very few men ever go into the Chapel. Little can be said in favour of any tablet or similar article in the museum; the present examples are not such as would make us wish for any more. There remains to us one much used resort of Guy's men, and that is the pavilion at Honor Oak Park. Some useful addition there, such as an oak wainscoting would be both a wise expenditure of money, and a permanent memorial. However, the first thing to be done is to start the ball rolling.

IN the defence of the foreign legations at Peking (*pace* the more elaborate spelling of last issue) much valuable assistance was rendered by the volunteers under Captain Poole.

LAST year the surgical firms became very keen on tugs-of-war, and much friendly rivalry existed therefrom. More or less of tournaments were held between teams of eight from each of the four firms, the heats usually provoking keen competition and much amusement to the bye-standers. To still further encourage this new development, Mr. Lucas presented a cup to be held by the winning team until such time as it should be successfully challenged. In the struggle that ensued his own firm came out on top, and the cup has been held by the "Leucocytes" ever since, no other firm having the temerity to challenge. With a view, therefore, to re-awaken public interest in the tug-of-war competition, a meeting was held last Wednesday of the surgical and medical firms, with Mr. Lucas in the chair, and the question was discussed whether the medical firms should be admitted to pull against the surgical people.

THE meeting was almost entirely surgical in nature. Nevertheless the question was patiently discussed, and even the suggestion that the "gynæcological people" should be permitted with the externs to form a team, was given a judicial hearing. However, there was none who could be found to speak on behalf of these surgical physicians, and their inclusion was not allowed. As the matter lies at present, teams representing the surgical and medical firms can now fight for the Cup. If the numerically weaker medical firms can pull it off, so much the better for them; if not, by their inclusion they will at any rate have added to the sport and enjoyment of the tugs-of-war. We shall await with interest the list of byes in the first round of this new competition.

MAY we remind present, past, and future Guy's men that the opening dinner of the Clubs' Union is fixed for Monday, October the First? May we also remind them that they are invited to bring their uncles, brothers, and cousins (m.), or any one else of the sterner sex they may choose thus to honour? It will be more convenient if application for tickets be made direct to Mrs. Batten, the stewardess of the Club, and not through the medium of the honorary secretary. There ought to be a big muster and a thoroughly successful evening with Dr. Hale White in the chair and the Treasurer lending support. So if any man does not want to be crowded out at the last moment he had better apply early for a ticket, more especially as by so doing he will materially help the work of organization.

ASSISTANT house-physicians receive many curious documents in the course of their appointment, but few probably will be able to match the annexed letter, which is the work of a very deaf old medical out-patient. Realizing that conversation is hopeless, he contents himself with handing in some such laudatory manuscript as this, and then reads a newspaper while the A.H.P. attempts a translation:—

Gentleman Physician

I Apologize So much Reading

June 22–6–1900.

Honorable and Esteem Sir

My Trobled Anxiety is Meditation of Mind Is a Little Releived In Offering up Priase To Superiorty. Theses Privaleged Gifts To be Able To Return Your kindness Is Most Virtuous Good Worth Eminent Thanking you For Ordering To be Prescribed In my Case Giving Attention To your Valuable Medcine I feal a Slight Change Setting and Laying I Thank in my Mind This Gentleman Influence Will Sone give Effect To the System. As Soon as i Begin to Wolk The Body is so Unpleasent Fealing not Able To Bear up Against this Restraint To Succeed To Renewed Strenght To become Strong As its Caused all through the Case Great Stooping For the great Wont of Strenght Holding any Weight In Frount of Myself Makes a great Impression brings great Thoughts in the Mind Doughtful To this Part In the Nable The Constitution Feals Declining Fast Fading Away So Feeble Week Infirm It Feals Weak Ads no Flesh To give Strenght To Advance To Yeald To the Perfection of Health——My Supplecations is a Pertition To Retrive To Recover To Regain Try to become Thriveing Instead of Reduceing So Very Thing in my Body It may be Giveng To Robust Stoutness As Our Supreme Can give the Power Most Rightious Good to us all This Part Sir In the Nable a Good Size Tea Cup Might make This Part Even or It Appears To Feal so To Lay In this Sinking in Hollow Part In the Nable To become Strenghtened Invigourated Purefied By Restoring the

Body To its Foremer Natural Healthy State To Become Renewed and Form a Level Stomach. As its quite Essential. My Body Feals To have Very little Inside Much Astonished with my Appetite Eat Very Hearty any kind of Food Is not necessary No incumberences. Beautifully Digested My Drink and Food and your Valuable Medicine Sir Does not Gather any Flesh To Yeald To Multiply In Strenght. After Eating which i think Its quite Enought The Body Does not Seem Satisfied Its Fealings so Poor and Weak I Feal not Satisfied Eat at any Time Its Just the Same as Something was Eating Away The Food Its Quite the Truth Sir The Body Feals In the Nable as If it was Starved My System Seems not Supported or Nourished With good Living To give that Support In Upholding Strenght Its Very Strange and Difficult To Apprihend In this Life There Is Many Changes May They Pass Through Satisfactory——I have a Eagor Ardency To Thank you For Your kind Attention and Care You Freely bestow as a Thorough Gentleman Trying Revive To Return To Vigor For a Longe Continuation of Years Rejoice In this World Happiness,—Your's Humble Obedient Patient.

Now that a new scholastic year is soon to be commenced, this may be perhaps a fitting occasion on which to ask for contributions of a literary nature from our readers. It is generally acknowledged that cases for diagnosis are of value, both from the educational and the purely scientific point of view. Varieties of disease which show obscure symptoms and signs, are generally worthy of permanent record, and always useful to the man who is shortly hoping to qualify. Medical ward-clerks are the people best situated to supply these cases, and it is to them that we especially appeal. There is no need always to wait for the autopsy for confirmation or refutation of the original diagnosis; sometimes quite late in the history of the case, events occur which make the diagnosis practically certain. What we want, then, is a short history and description of the case, and then, separately, the autopsy or confirmed diagnosis. Dressers and surgical ward-clerks usually lack the material for "cases for diagnosis," but should anything of more than ordinary interest be taken in, we should like to hear of it.

Two Guy's men have become the unwilling guests of the Boer rebels. According to War Office report Dr. A. C. Fry and Private A. Moon, his medical orderly, of the Imperial Yeomanry, have been captured. Fortunately, it is believed that neither is hurt.

EVER since one can remember the college lavatories have been in a continual state of tinkering. Usually the hand-basins have been under repair, or the water pipes have been on furlough, and when basins and taps have both been working with maximum efficiency, then the waste pipes have got sulky and refused to carry away the used water. Most men will have experienced the overflows which periodically add to the enjoyment of residents in the college and members of the Clubs' Union. During the present summer baths have been almost an unknown quantity, except during a brief period in the morning, and now when London generally is plentifully supplied with water, the mains supplying the college and hospital have run quite dry. Of course the blame for this state of affairs lies outside our walls, but this only adds to the irritation. We are all anxiously looking forward to the sublime future when we shall be entirely self-contained, and willing pumps shall force water from our own wells into the college tanks.

Notice.

THE LONDON SCHOOL OF TROPICAL MEDICINE
Connaught Road, Albert Dock, E.,
In connection with the Hospitals of the Seamen's Hospital Society.
The next Session will commence on Monday, the 1st October, 1900.

SIR WILLIAM MACGREGOR, K.C.M.G., C.B., M.D., D.Sc., LL.D., has consented to give the Opening Address.

For Prospectus, Syllabus, and other Particulars, apply to P. MICHELLI, Secretary,
Seamen's Hospital Society, Greenwich, S.E.
Or to DR. REES, the Medical Tutor, at the School.

Papers by Guy's Men.

A Case of Diffuse Suppurative Peritonitis from Gangrene of the Appendix; Laparotomy; Recovery. With Notes on the Frequency and Mortality of Peritonitis. By Henry A. Duffett, F.R.C.S.—*Lancet*, 8th September.

Four Surgical Cases. By Mr. W. H. Jalland. (Illustrated.)—*Ibid.*

The Imperial Yeomanry Hospital. By A. D. Fripp, M.S., F.R.C.S. (Illustrated.)—*Ibid.*

Introductory Remarks delivered at the Opening of the Section of Ophthalmology, Annual Meeting of the British Medical Association. By W. A. Brailey, M.A., M.D.—Ocular Headaches.—*British Medical Journal*, 11th August.

The Vocal Resonator. By William A. Aikin, M.D.—*Ibid.*—September 8th.

Treatment of Chorea. By James W. Russell, M.D.—*The Birmingham Medical Review*, September.

Campaign Notes.

1st Mounted Infantry Brigade Camp,
Pan (14 miles E. of Middleburgh).
August 7th, 1900.

Although the interest in this campaign must be to a great extent subsiding, I thought a short letter might be not uninteresting. It is two months since Pretoria was occupied by Lord Roberts' troops, and to us out here the end of the war seems further off than it did then. The resistance offered by the Boers since Pretoria has been occupied has been greater than at any time during the march from Bloemfontein. Our officers out here say that the Boers are unequalled in fighting rearguard actions. They certainly ought to be able to fight them well, as they have had plenty of experience. Shortly after Pretoria was taken we were ordered to proceed north-east towards Witkirk, and about thirty miles from Pretoria we had a stiff fight, although fortunately attended with few casualties. General French, to whose column we are attached, was on the left flank, and one morning about 8·30 we heard firing ahead. We had had reveillé at 3·30 a.m., and had started at 5 a.m. At four o'clock the moon was shining, but at five it was pitch dark. One constant feature of this country is the presence of large holes four or five feet deep and a foot or two in diameter. Trekking across the veldt on horseback in the dark is on this account not pleasant. Bad accidents from one's horse falling are not common, although only two days ago I had a case of fractured clavicle from this cause. Firing always has a great attraction, and everybody, even surgeons, want to know where it comes from. Consequently, when we heard firing, everyone hurried forward, and it was fortunate we did so, as after we had crossed a drift at the foot of a high kopje, called Lowe's Beacon, shells began falling all around this drift, and we found ourselves cut off. The Boers were also on our right flank and in front of us, and for about three hours we had a very warm time. This was one of the occasions on which the ambulances were shelled, although I am quite sure it was unintentional. The ambulances naturally wished to get out of fire, and in doing so they hurried rather much, and so raised a great dust. This of course the Boers could see, although I feel sure they could not see the ambulances, and consequently they shelled us vigorously. This caused the ambulances to hurry still more, and raise a still greater dust. The nett result was one mule wounded, the lamp blown off one of the ambulances by a pom-pom shell, and everybody very frightened, very much out of breath, and the use of much bad language chiefly directed at the mule-drivers for being so slow. Fortunately nobody was hit, although one man was bruised by a fragment of a pom-pom shell. We had two days' fight here. I met Mr. Watson Cheyne on the second day. He had had rather a bad time an hour before I met him. He had been arranging his valise to lie down in a corrugated iron house, used temporarily as a hospital, when a fifteen pound shell came through the wall within a yard of his head.

On the third day the Boers trekked north, and we followed them for about fifteen miles, but were unable to follow them any further as our force was not strong enough. We returned to Deerdepoort, a pass about nine miles north-east of Pretoria, where we were bivouacked. We had no tents, for about a fortnight.

There is a lot of malaria around Pretoria, especially to the north and north-east. The country, although hilly, contains many vleis (pronounced flays), which correspond in England to marshes, but which are very small as a rule, being usually about fifty or a hundred yards in diameter. Since so much discussion is going on as to the origin of malaria, I will do no more than say that when we are camped near any of these vleis for any time, we invariably get a number of cases of malaria, which are as a rule of a mild type. The formation of the country around Pretoria is interesting. The hills, ranging from 1,500 to 2,000 feet above the surrounding country, run in parallel lines, leaving long fertile valleys between. I have entered one of these valleys and travelled thirty miles along it, without seeing where it began or where it ended. There are many of these lines of hills, and looking down on them from a high kopje, they look like waves of an enormous sea.

The soil in the Transvaal in many places is the finest in the world; dark, rich, fertile, virgin soil. And yet it is impossible to get potatoes, except occasionally as a rare find on one of the scattered farms of the veldt. Almost all the butter that we get is imported; tinned butter from Denmark, 7,000 miles away, in a country many times as large, many times as fertile!

We are now encamped at Pan, a station on the Delagoa Bay Railway, waiting for orders to advance. We have the Suffolk Regiment here, to which the Cambridge University Volunteers are attached, and some other Infantry Regiments. One sees the effect this big country has on infantry. We have had many cases to treat of dilated hearts, and soreness and strains of feet. Among the mounted infantry, to which I have been attached for over three months, we have had none of this.

The climate out here is very healthy, but the temperature is very variable. In the middle of the day it is scorching, and khakhi drill is the most comfortable stuff to wear, but at night it gets very cold. I put on a thick waistcoat, an "European warm" coat, and a thick cavalry service cloak, and with these on and sitting close to a good camp fire, it is cold enough to make one shiver, We sometimes have more than half an inch of ice on the water in the morning. As I am finishing my letter, a train is just going through towards Machadodorp, full of Boer women and children, sent, I presume, by Lord Roberts to the Boer laager. They are travelling in open goods trucks, as everyone travels here, officers and men. We had heard that despatches had been sent by Botha to Lord Roberts—this is, presumably the reply. This is, I am afraid, a very disconnected letter, but I am beginning to forget what letters are like, we get so few mails, and these, as a rule, months old.

S. E. DENYER.

In Lighter Vein.

An Imaginary Dialogue.

"Talking of white elephants," she said, helping herself to bread and butter, "I know a story of one which you might like to hear. Perhaps you would kindly listen to me for a moment, instead of watching Nurse."

I started guiltily, and murmured something about elephants being awfully jolly things.

"I knew you were not listening, otherwise you wouldn't have made such a silly remark," and her voice had just a suspicion of triumph in it.

"Really, Sister, I must apologise. I'm awfully rude, I know; but, still, Nurse looked so charming in the sunlight."

"Nurses have no right to look charming."

I protested.

"But they make Sisters out of Nurses."

"Don't be so silly, but listen to me."

She carefully selected two lumps of sugar and dropped them into her tea-cup; then she began—

"There was once a Sister who had a grateful patient——"

"Sounds quite interesting," I said, pausing with a biscuit in mid-air.

"Don't interrupt, and do try and be sensible. Well, this Sister was very kind to the patient——"

"No!—er—I beg your pardon, Sister."

She frowned severely at me. She has very pretty eyes.

"And when the patient got well——"

"Some diseases are never cured, Sister," and I sighed heavily.

"He went home and sent the Sister up a large box of—— Guess!"

I tried all manner of things; but not knowing the Sister, I made very poor shots. I admit old clothes to be a most clumsy attempt, and sufficiently worthy of another flash of those eyes. They really are very pretty eyes.

"White heather!"

She paused.

I laughed because I thought it was expected of me. I was evidently on the right track, for she laughed too. You know she has a most charming laugh.

"And the cream of the joke is," she said, "that the Sister had to pay ten shillings for carriage on that box."

I rose and held out my hand. I wanted to go away and enjoy the cream of the joke.

J. M. B.

Some Notes on the Imperial Yeomanry Hospital.

Imperial Yeomanry Hospital,
Deelfontein,
July 16th, 1900.

Since I wrote to you last I have been up to Mafeking to fetch Major Mullins, who is now safely located in one of our officers' wards here. He was so badly wounded in the backbone that we had to get a truck with sufficiently wide doors to admit the bedstead complete, and the guard's van was the only carriage that would meet the case. We brought down Mr. Hands, the *Daily Mail* correspondent, who also had been wounded in the relief, at the same time, so that there is not a single seriously sick or wounded man now left in Mafeking. I had been suffering from a poisoned finger, and the rest from work enabled it to get quite well. At the same time the trip afforded a most interesting experience. The "dug-outs" or "bomb-proof" shelters have most of them disappeared already, for their roof was generally made of railway metals which had to be restored to their proper place before the line could be re-opened. Fuel is still very scarce up here, the locomotives having to depend on wood, of which they draw a huge truck after them. Of food there is plenty, and of danger there is none, though there was indeed a slight skirmish only seven miles out of Mafeking while I was up there, and the passengers by the train after ours saw a couple of shells bursting not long before they reached Mafeking (there seems to be various small commandoes of the enemy moving about even in parts of the country that have for many weeks been considered disarmed. There is one such between us and Kimberley, and another between Norval's Pont and Naauwpoort, a slight skirmish taking place the other day at the former place). But in all other respects very little change has as yet come over Mafeking since it was relieved. It is a most interesting thing to be taken over the forts and trenches by one of those who was responsible for their making, and who knows the why and wherefore of each move and of each fight. The "Brickfields" in particular might be described as a chess-board on which a most clever and spirited game had been played for several months for great stakes. There, as I dare say you know, our trenches were pushed up to within sixty yards of the Boer trenches before the latter were evacuated, and then our men sapped on until the two trenches joined and they could pass all the way under cover from one of our forts to one made by the Boers. The latter they found was evacuated, but luckily before occupying it they stumbled on an electric fuse wire and cut it, and then found two hundred and fifty pounds of dynamite which was meant for their destruction. This was thirteen hundred and fifty yards from the market square, and eight hundred yards from the main Boer position. They were hard up in the town for some wire of this sort, so they

picked up the cut end and began to haul it in before the Boers, who were ineffectually pressing the button which made the connection which was to have blown up the fort, discovered what was happening. A tug-of-war ensued and our men got seven hundred and fifty yards and the Boers only fifty. Trophies and mementos of the siege of all sorts are in great demand both at Mafeking itself and also down country. Siege stamps, paper money, shells and bullets, occupy the most prominent place in most people's minds, and realize most extraordinarily high prices, but Professor Chiene, who was visiting us not long ago, is the possessor of one of the most interesting mementos in the shape of a concertina whereby, in conjunction with the noise made by a native dancing on a sheet of corrugated iron, the Boers were tempted to put up their heads when only separated from our sharpshooters by the sixty yards already mentioned. Many Boers paid for their curiosity with their lives, for the moment anything showed above the sandbags it got a bullet through it; even a cartridge case, which is only two and a quarter inches by less than half an inch, left by chance on the top of the sandbags got two bullets put through it. I daresay you know that there are some field-glasses made on such an arrangement of angles and prisms that by their aid a man in a trench can spy over the top without exposing his head. I saw one such glass which had had a Mauser bullet bang through its lens, which passed also through the hat of the person who was using it. The Stadt, or native compound, is another very interesting part of the besieged area to visit. It stands separated from the town by a small river bed. The force which occupied this quarter of the outer and inner circles of forts was usually composed almost entirely of natives. Twice at least this native stadt was the object of a hot attack. On the first occasion the Boers broke through the outer circle of forts which surround the town at a radius of about a half to one mile, but were repulsed at the inner forts which closely encircle the town. On the second occasion, 12th May, headed by Eloff, the Boers, as you know, got right into the stadt and set on fire many of the native huts. They pushed on and got almost to the railway station. Reinforcements of white troops then got round behind them and cut off their retreat. Here many of them surrendered towards nightfall, but of those who tried to retrace their steps through the stadt it is said that some were thrown by the natives into the burning houses. Both at Mafeking and at Ladysmith the besieged forces seem to have placed a very modest estimate of the splendid services they yielded. An officer who was in Ladysmith said to me the other day, "When the relief force came in, we were surprised to find that we were heroes, we thought that we had all been doing very badly." And one I saw at Mafeking, who, on the testimony of his colleagues, seems to have taken a most active part in the fighting, and indeed in the most dangerous parts of it, said, "Our success in keeping the enemy out is due not so much to what we did as to what the enemy failed to do." Both the convent and the hospital were, as you know, severely damaged by shell fire. The former, which is the only two-storied building in the town, and therefore afforded a tempting target from the Boer lines, might almost be described as a ruin, but the latter is the one building in the town which has already been repaired. Throughout the siege they seem to have been remarkably free from sickness, despite the fact that Mafeking is as innocent as any other town in South Africa of any attempt at sanitation.

I am glad to say that sickness among the Staff here has materially diminished of late. Only twenty-one of our orderlies are "in hospital," and they are all doing well, and so are the two doctors who are convalescent from enteric, and a couple of sisters who are off duty for slight ailments. This most satisfactory statement seems to be general throughout the country. The epidemic of enteric continues to rapidly decrease. Sloggett, who is just back from Pretoria, whither he had to go to make arrangements for the new advanced branch of the Yeomanry Hospital, the first instalment of which is due at Cape Town to-morrow, says that there are only four hundred sick and wounded in that city, and only sixteen hundred in Bloemfontein, instead of the five thousand that there were when I was there six weeks ago. He says that there are two whole general hospitals now in Kroonstad besides the Glasgow Hospital of three hundred beds, but there, as at Kimberley, where I visited the hospitals on my way to Mafeking, and everywhere else that the hospital trains ply to, the report is extremely favourable, and there are vacant beds everywhere now. The difficulty of transport, however, continues. Between Kroonstad and Johannesburg it is even greater than it was, owing, of course, to the depredations of Christian de Wet.

We have taken in nearly two hundred and fifty patients this week, including one train from Wynburg, half sick and half wounded, and one train load of convalescents from Pretoria, and about fifty Yeomanry including a batch of the Warwicks and a batch from Kimberley.

From talking to Boer prisoners it is evident that their leaders are still trying to buoy them up with the most gross misrepresentations. One said that his commando had been told that six million Russians had been landed at Cape Town, and that Cronje and all his men had escaped from St. Helena and were invading the Cape. They say the Boers have changed the name they apply to our troops from "Rooineks" to "Locusts."

On my way through Kimberley the other day I ordered and brought down with me on the return journey a marble cross for the head of Fitz-Hugh's grave. About a week ago the Coadjutor Bishop of Cape Town paid us a twenty-four hours' visit for the purpose, firstly, of dedicating our burial ground, and secondly, of holding a confirmation service, for which some eight or nine candidates had been prepared by our clergyman, Mr. Blackbourne.

We have experienced a day or two of really horrible weather here lately. Tremendously high winds, very cold indeed, and bearing along clouds of dust and even

of shingle, which feels at times almost like a flight of small shot. Several of the larger tents, including the sisters' dining-tent, poor souls, were blown down, and it has been impossible yet to put them up again owing to the continued high wind. None of the tortoise or bell-tents have been blown down, nor, of course, were the huts damaged, but everything and everybody has been covered with dust.

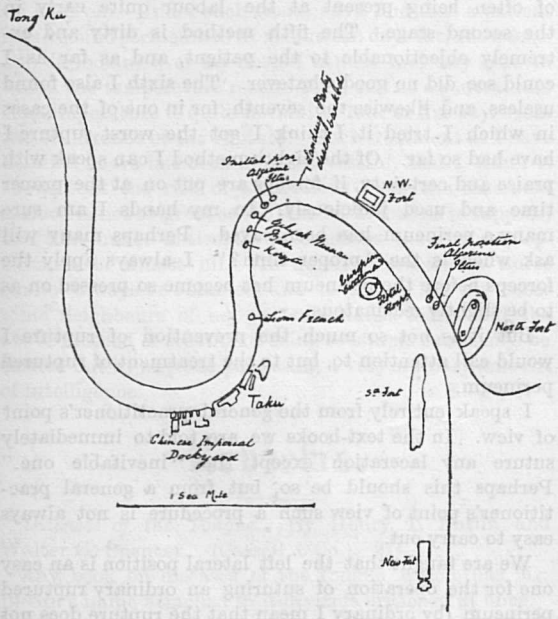
A. D. FRIPP.

The Taking of the Taku Forts.

(FROM AN OCCASIONAL CORRESPONDENT.)

H.M.S. Algerine,
Taku, June 23rd.

The following short account of the taking of Taku forts on June 17th may be of interest to your readers.



Owing to the situation in China the authorities in charge of the forts shown in diagram received an ultimatum signed by the heads of the combined squadron that the forts were to be given up "for temporary occupation by the Allied Forces" otherwise they would be fired on at 2 a.m., June 17th (forty-eight hours' notice was given).

The following is a copy of the log of H.M.S. Algerine which, with reference to the chart annexed, gives the account in the shortest manner possible.

"12.50 a.m. Forts opened fire simultaneously on Allied Squadron.

Went to quarters and returned fire of forts at 12.51½.

2. Landing party disembarked on north bank.

5.50. Weighed and proceeded down river, engaging south fort, the north-west fort having been captured by British and Japanese, and the north fort by British, Japanese, and Russians.

6.30. Anchored (final position).

7.10. Forts ceased firing.

8.15. Landing party returned with sixteen prisoners.

9. Hands employed clearing up deck and restoring ammunition and repairing damage aloft."

It should also be noted that landing parties of Germans, Japs, and Russians started about 12 for their respective forts. The Russians taking the south and new forts about 7 a.m. as their fire was silenced by the ships.

The Iltus accompanied the Algerine throughout the engagement, the other four ships continuing the bombardment from their original anchorage.

A Case of Suppurative Pericarditis with Operative Treatment.

EDW. W., æt. 8, was admitted on July 16th, 1900, und Dr. Fawcett for pyrexia and dyspnœa. His family history was bad, while he had suffered from the usual children's ailments, and had never been a healthy child.

His mother gave a history of a slight accident six days before, followed by a pain in the right side, with fever and delirium. On admission to the hospital (temperature 100·4°, pulse 135, respiration 65) he was found to be suffering from a right basal pneumonia. The cardiac dulness was also found to be increased, reaching above to the second rib and extending just beyond the right border of the sternum and out to left mammary line; no abnormal sound was heard. The liver edge could be felt several inches below costal margin.

On the 17th the cardiac dulness extended up to the first rib, and fully an inch to the right of the sternum; a pericardial rub was audible in the fifth left space, close to sternum.

On the 27th it extended above to the clavicle and one and a half inches outside the left mammary line; compression signs appeared behind, internal to angle of left scapula; the rub was variable.

In the meantime the signs of pneumonia were clearing up, although the temperature still remained high and the pulse very rapid.

The advisability of tapping the pericardium was discussed at this stage, and an exploration needle was inserted in fourth left space, half an inch from sternum, pushed in one and a half inches, and the point directed outwards. A purulent fluid was obtained.

Three hours after, patient having sufficiently recovered, he was put under the smallest possible amount of A.C.E., and an incision was made over the fifth left costal cartilage off which the perichondrium was stripped, and three-quarters of an inch of the cartilage removed. The exposed pericardium which was thick, tough and fibrous, was opened, and four or five ounces of thick creamy pus exuded.

A short quarter-inch drainage tube was stitched in and the usual dressings put on.

The patient stood the operation well; his pulse distinctly improved, and for several days his condition seemed favourable; a great deal of discharge came away. Soon, however, he became visibly worse; some bronchitis set in, and his temperature assumed a hectic character, running up to 103° at night. The liver was pushed down to umbilicus, and as right side of chest remained dull an exploration was made on August 10th, and pus was discovered. The same night the pleura was opened and drained. For three days the temperature remained good, but on the fourth day after the second operation he showed signs of collapse. Stimulants proved useless, and he died early the following morning.

At the autopsy some left pneumonia was discovered; the right lung was fibroid with dilated tubes, and there were signs of old pleurisy. The pericardium was thickened, with lymph on surface, and contained a little pus.

There was capsulitis of both liver and spleen, while the former organ was tough and much enlarged.

G. E. M.

Prevention of Lacerated Perineum and Treatment.

FOR some weeks past there has been an interesting discussion on the prevention of Rupture of the Perineum in the *British Medical Journal*.

I will enumerate the various methods cited in case some of your readers have not seen the discussion in question.

i. "Free lubrication of the perineum (with what the correspondent does not say) and 'WAIT.'"

ii. "Wring out a big towel in hot water, roll it into a ball and dip it into a saucer of oil. Apply and keep it in position with the hand. It's action is 'pleasant,'"

iii. "Draw the perineum downwards and backwards during each pain, from the commencement of the second stage of labour, and keep the limbs in a line with the body."

iv. "At the crucial moment, just as the head is about to be expelled, the woman should completely abandon the obstetric position, and should stretch out her legs as far as possible, at the same time partially turning over on to her face."

v. "When the occiput is engaged under the symphysis pubis and the face is sweeping over the distended perineum, I press with the fingers against the forehead in the direction in which the head will be carried; and if laceration seems imminent, I introduce two fingers into the rectum, and by hooking up the chin I am able to increase very decidedly the extension and also hasten the expulsion of the head."

vi. "I would recommend the application of chloroform on lint, covered with oiled-silk, to the perineum, carefully watching; if smarting is produced dilute the chloroform with rectified spirits."

vii. "In a 'petite primipara' I make an incision on each side nearly half an inch long, directed backwards, and about one inch above the fourchette, these incisions become lacerations over an inch long, giving ample room for the passage of the head and require no sutures."

viii. "I am afraid I shall be accused of meddlesome midwifery when I say as the result of thirty-five years' practice, I have become very strongly convinced that many a primiparous perineum may be saved by the early and judicious use of forceps."

Here we have no less than eight methods for prevention of ruptured perineum. I have tried all. The first is absolutely useless and a great waste of time. The second method likewise has only its "pleasant action" to recommend it, otherwise it seems method number one elaborated. Number three failed with me in spite of often being present at the labour quite early in the second stage. The fifth method is dirty and extremely objectionable to the patient, and as far as I could see did no good whatever. The sixth I also found useless, and likewise the seventh, for in one of the cases in which I tried it, I think I got the worst rupture I have had so far. Of the eighth method I can speak with praise and certainty, if forceps are put on at the proper time and used judiciously. In my hands I am sure many a perineum has been saved. Perhaps many will ask when is the "proper time?" I always apply the forceps before the perineum has become so pressed on as to be slightly œdematous.

But it is not so much the prevention of rupture I would call attention to, but to the treatment of ruptured perineum.

I speak entirely from the general practitioner's point of view. In the text-books we are told to immediately suture any laceration except the "inevitable one." Perhaps this should be so, but from a general practitioner's point of view such a procedure is not always easy to carry out.

We are taught that the left lateral position is an easy one for the operation of suturing an ordinary ruptured perineum (by ordinary I mean that the rupture does not extend through or into the Sphincter Ani). I have seen many perineums which have been sutured in this position, and in every case there has been a bad result, as shown by the "pocketting" and an irregular and lumpy scar, and this results from the fact that it is very difficult to introduce sutures into a perineum (with the patient in the left lateral position) to emerge exactly opposite to the point of introduction, and that when tied you get a marked "rucking." This "rucking" is probably not noticed until the patients assume some other position. And on examining such a perineum after some weeks one often finds a kind of "pouch or pocket" behind the vaginal outlet. I have often mentioned this fact to practitioners and teachers and the remedy they suggest is "Don't sew up a perineum in the left lateral position, but give chloroform an hour or so after delivery and

put your patient into the ordinary lithotomy position, and then insert your sutures." Certainly this is correct. But how can you carry out such a proceeding in a country practice miles from a colleague, to whom you would have to give a guinea for his help, leaving you minus a fee for your care? And certainly no one could recommend a man to give the anæsthetic and operate himself.

To overcome all the above difficulties I now never suture a ruptured perineum, but treat the patient in the following manner. I have the genitals carefully cleansed every four or six hours with a solution of Izal, ʒi. to two pints of water, and a clean diaper given every four hours (the diapers are always washed in an izal solution). A vaginal douche of warm izal solution, ʒi. to two pints of water, is given night and morning, and the patient's legs are kept tied together. The bowels are opened daily by enemata for the first week or ten days, and then Pulv. Glycyrrhiz. Co. is given. Under such treatment I find that a patient gets a sound perineum in from fourteen days to three weeks, and on looking over my notes I cannot find any case in which the temperature rose to 101°, and as a general rule the temperature is quite normal in four or five days from the occurrence of the rupture. Such treatment as I have detailed above has been most successful, and I think it shows that the risk of absorbtions from the lacerated surface is not so great as the text-books lead us to suppose, and that under antiseptic precautions the risk of septicæmia is almost nil. In country practice a nurse cannot always be obtained, and in nearly all my cases some neighbours of my patients nurse them, and the above method of treatment being so simple can easily be carried out by any one possessing a very ordinary amount of intelligence.

E. F. C.

Reviews.

Diseases of the Tongue. By Henry T. Butlin and Walter G. Spencer. (Cassell & Co.) 21s.

Any book on diseases of the tongue which has Mr. Butlin's name attached to it disarms criticism at once.

It is fifteen years since this book was first published, and although it has been reprinted it has not been re-edited until now.

The new edition has received considerable care and attention from Mr. Spencer, who is also responsible for much of the pathology.

The arrangement of the book is good, each chapter being devoted to one of those headings under which all of the various organs of the body might be described when description is needed of the various morbid changes to which they are liable. After a short description of the anatomy, we pass on to the congenital defects, injuries, &c., through chapters on various inflammations, new growths, and the treatment of the tongue, both operative and otherwise.

Numerous woodcuts are to be found, and some excellent coloured plates, twenty-four in number, representing various ulcers and changes seen on the tongue, and reproduced from clinical cases. These add considerably to the value of the book.

A list of authorities and references to various articles in home and foreign literature on the subjects treated of in the book, also an index, complete a work which we can confidently recommend to all Guy's men.

Things Seen. By G. W. Steevens. (William Blackwood & Sons, London and Edinburgh.)

Messrs. Blackwood have, in the issue of this collection of miscellaneous papers, published volume I. of the memorial edition of Steevens' works. To those who were familiar with his writings, and appreciated his singular capacity for forming correct estimations of things seen, this present volume must serve merely as a confirmation of the opinion that in Steevens lay endless potentialities and a promise of infinite greatness. But even the casual reader, the whiler-away of half-hours, must be struck with the intense reality of everything that Steevens tells. From our own point of view we were naturally most struck with the article, "Two Hospitals," in which the details of an afternoon's sitting at out-patients, and a second afternoon in the operating theatre, are displayed with a dramatic force which appeals to the student and layman alike. Certainly a book to be read.

Electricity in Gynæcology. By Richard J. Cowen, L.R.C.S. I., L.R.C.P. I. (Baillière, Tindall & Cox.)

This little book is intended to be a practical guide to the use of electricity in gynæcology. The uses of electricity and the benefits derived from it as a therapeutic agent in those diseases peculiar to women seem, if we are to rely on the author's statements, legion. He advises its use for amennorrhœa, menorrhagia and the menopause, flexions of the uterus, suppurative lesions, fibroids, and diseases of the tubes, and, in fact, leaves it extremely doubtful whether there is any ailment peculiar to women which cannot be alleviated by means of electricity. So valuable a therapeutic agent may well be recommended to the medical practitioner. To those who are in want of some practical hints as to the application of electricity as a therapeutic agent, we can recommend the book, but we are sceptical as to the beneficial results accruing to its use claimed by the author.

Medical Monograph Series No. 3.—Appendicitis. By A. H. Tubby. (Baillière, Tindall & Cox.) 2s. 6d.

This small half-a-crown book is presented to the profession as a concise account of appendicitis, its pathology and treatment, the material having been culled from the writings of sundry and various writers on this subject and reduced to some ninety pages. It is based chiefly on Dr. H. P. Hawkins' work, and is a readable and satisfactory account of the subject, carrying out the aims for which the series is published.

Hernia: Its Etiology, Symptoms and Treatment. By W. McAdam Eccles. (Baillière, Tindall & Cox).

This book, dedicated to the students of St. Bartholomew's Hospital, is not intended to give us any new facts, but is one of those books, written by the junior members of the staff of a hospital who are engaged in teaching, and to whom the presentation of a subject is always from an examinational standpoint, and from that point of view this book must be considered, otherwise we hardly think there is a call for a book on the subject of hernia, it being a subject well treated in every text-book.

One feature of this volume is the number of pictures and illustrations. We have had to speak on previous occasions of the want of good illustrations and clear diagrams, also of the uselessness and inadequacy of many illustrations in some recently published works, but here we have numerous pictures, many being photographs, and on the whole very well done, consequently we congratulate both author and publisher on recognising the usefulness of illustrations in all books which are specially designed for the student.

Another feature of the book is the number of tables arranged with a view of assisting the reader to a differential diagnosis of various similar swellings in the inguinal, femoral and scrotal regions, etc. These tables are arranged in such a way that the student can tell in a moment what are the possible sources of error in diagnosis.

The last chapter is devoted to hernia in relation to life assurance, accident insurance, the public services, clubs, colonies, etc.

In the future probably we shall find that men going in for the higher examinations will prefer reading a separate monograph for each subject rather than take one of the bulky works on general surgery, especially as the "systems" by various authors show such an inequality among the writers, and this book of Mr. Eccles may safely be recommended to those who wish to read up the subject of hernia.

ALSO RECEIVED.—Septic Diseases of the Puerperium, reprinted from "Treatment." By T. G. Stevens, M.D., M.R.C.P. Lond., F.R.C.S. Eng., Hospital (4), Clinical Journal (4), Polyclinic, St. Bartholomew's Hospital Journal, Treatment.

Appointments.

CIVIL.

BOWEN-JONES, L. M., L.R.C.P. Lond., M.R.C.S., D.P.H., has been appointed Medical Officer of Health for the Borough of Carmarthen, *vice* W. L. Hughes, deceased.

ENSOR, C. A., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of Health for the Tisbury Rural District, *vice* J. A. Ensor, resigned.

MILITARY.

Surgeon-Lieutenant J. W. Nicholson, 1st Volunteer Battalion the Lincolnshire Regiment is promoted to be Surgeon-Captain.

Sport.

Cricket.

2ND XI. CRICKET, 1900.

The 2nd XI. list of fixtures concluded with the match against the Hos.-Scho. on July 14. The season cannot be described as otherwise than satisfactory. Guy's has not turned out so strong a second team for some years past.

Of the 15 matches arranged, 13 were played. Of these, 7 were won, 1 lost and 5 drawn. Of the drawn matches, two, viz., those against St. Thomas's and Old Charlton were overwhelmingly in favour of Guy's.

Morgan with an average of 48 for two innings, Collins 25·5, Tolhurst 20 and Bowle 20, possessed the best batting averages.

Chignell took 16 wickets at a cost of 7 apiece; Bowle 22, with an average of 10; and Carlisle 16, with an average of 11.

Births.

CLARKE.—On August 18th, at Windsor House, Morley, the wife of Travers Clarke, L.R.C.P. Lond., M.R.C.S., of a daughter.

PRINCE.—On September 10th, at Egremont, Reigate, the wife of Peregrine Charles Prince, M.R.C.S., L.R.C.P. Lond., of a son.

RYLE.—On August 19th, at German Place, Brighton, the wife of R. J. Ryle, M.A., M.D. Oxon., M.R.C.S. Eng., of twins (boy and girl).

Marriages.

CLEVELAND—JACKSON.—On August 11th, at St. James's, Kidbrook, Arthur John Cleveland, M.D. Lond., M.R.C.P., youngest son of the late Henry Cleveland, of Blackheath, to Evelyn Mary, elder daughter of Edward Jackson, of Blackheath, and Karachi, India.

DAVIES—WOODFIELD.—On August 29th, at St. Stephen's Church, Redditch, by the Rev. S. Davies, M.A., assisted by the Rev. A. E. Price, M.A., Hugh Davies, F.R.C.S. Eng., M.B., B.S. Lond., Vale House, Greenwich, eldest son of Mr. Davies, Lledfron, Llanfyllin, North Wales, to Elizabeth Victoria (Lily), fifth daughter of William Woodfield, Elmsdale, Redditch.

TAYLOR—SOUTHALL.—On August 10th, at the Friends' Meeting House, Bull Street, Birmingham, E. Claude Taylor, M.D., M.S., of Eland House, Hampstead, and Huldah R. Southall, daughter of Alfred Southall, of Birmingham.

Death.

ENSOR.—On September 4th, at Tisbury, Wiltshire, John Arthur Ensor, M.R.C.S., L.S.A., aged 58 years.

ED.—S. H.

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Calendar of Coming Events.

October, 1900.

Mon. 1.—Messrs. Lucas and Lane's take-in; Drs., G. Evans and R. C. Lawry; Cl., F. W. Sime.
Winter Session begins.
Students' Club Dinner.

Tues. 2.—First Conjoint Exam. begins.

Wed. 3.—G.H.R.F.C., I. Trial Game, home.
G.H.A.F.C., I. Trial Game, home.
1.30 p.m., Clinical Lecture by Mr. Howse.

Thur. 4.—Second Conjoint Exam. begins.
Messrs. Golding-Bird and Dunn's take-in; Drs., E. S. Allport and W. O. Roberts; Cl., M. D. Wood.

Sat. 6.—1 p.m., Clinical Lecture by Dr. Pitt.
G.H.R.F.C., I., Kensington, home.
II., Kensington, away.
III., Catford Bridge, 2nd, away.
G.H.A.F.C., I., Trial Game, home.
G.H.P.P.S., General Meeting.

Mon. 8.—November Appointment List opened.

Tues. 9.—Final Conjoint Exam. begins.
Second Part Camb. D.P.H. Exam. begins.
Meeting of Dental Society at 4.30 p.m.
Test Exam. for L.D.S. Eng.
Schedules for L.D.S. Eng. with the Certificate of Mechanical Dentistry, already signed, to be left at the Medical School Office not later than this date.

Wed. 10.—1.30 p.m., Clinical Lecture by Mr. Howse.

Thur. 11.—Messrs. Jacobson and Fripp's take-in; Drs., M. J. Rees and A. Wylie; Cl., J. A. B. Hammond.

Sat. 13.—1 p.m., Clinical Lecture by Dr. Pitt.
G.H.R.F.C., I., Lennox, away.
II., Lennox, home.
G.H.A.F.C., I., Old Harrovians, home.
II., Central Tech. College, away.

Guy's Hospital Gazette,

SEPTEMBER 29, 1900.

Caveat Lector.

FOR many years past it has been the custom to congratulate new arrivals at this hospital on the wisdom of their choice. By this means we are enabled to pat ourselves on the back and insist that as a body corporate we are very fine indeed, and at the same time impress upon the freshman his extreme insignificance and the very great honour that he has received in admission to our ranks. Since, however, the choice of a hospital generally depends largely on sentiment, congratulations of this nature are as a rule misplaced, and we find no necessity for impressing upon our recruits, by the aid of statistics, that they have joined the finest school in the world. They must already think so, independent of any figures; they must have accepted the dictum as an article of faith, otherwise they should not be here, for no one who is worthy of his salt would forswear his own school. If, then, the freshman would seek confirmation of his choice, he must look elsewhere. If his heart has any misgivings, he is no true son of Guy's and will best seek a home outside these walls.

Looking back, along the misty paths of time, we find that there is much that must be learnt by the freshman before he can walk with the firm step of a Guy's man. The road is steep and rugged and he must pave it for himself with the priceless stones of experience. He may read much; but the knowledge that makes the wheels roll smoothly is not found in any book. For consider, when you enter this hospital for the first time and find your way with much misgivings into the slate-walled room at "the other end," you are entering upon a new life as a man, when perhaps but two months ago you were subject to the many petty restrictions incidental to the life of a schoolboy. You will not have changed; your mental attitude will be the same, but you will find the environs on which you are forced to react are different in every detail. Thus it is that in your new-born

liberty you shout aloud "I am a Guy's man;" demonstrating to all that listen, that you are still a schoolboy. While the new found liberty of action still presses heavily upon you, you realize for the first time that the compulsion of attending to your work is as yet remote and you rejoice in the cutting of lectures. Your briar-root pipe, too, has not yet lost its newness, and in the gladness of your heart you flaunt this emblem of your franchise in the places where smoking is forbidden. But after a time your crudities will be softened and you will learn that your new life has its restrictions, while its responsibilities and duties are infinitely great. And you will find that there is much to be overcome in a very limited space of time, and, realizing this, you will sink your buoyancy in honest work.

Even then you will not have learnt the lessons of your first year. The careful observer will be able to detect in you a strong proclivity to the talking of shop, a vice, above all in our profession, to be abhorred, and to the acting of shop, more especially at meal times. By this means you will seek to impress your lay friends with the vastness of your learning and the wideness of your experience. You will for a time throw back to the medical student of Dickens and nullify the civilization of fifty years; and on the occasions when your hospital is engaged in the annual cup competition you will go down to Richmond attired in many colours and make noises quite foreign to your newly-acquired dignity. All of which things show that your probation is as yet incomplete. After a time you will finish your "second" or your "intermediate" and you will find yourself entering upon another of your hospital lives. And here, at the commencement, a word of warning. Do not for one moment imagine that your previous experience, such as it may be, will stand you in any stead. You will find that you are thrown into more or less intimate relations with a number of men senior to you, who have been through the mill of the junior appointments and expect the very utmost from you. To you, in your absolute freshness, there is a strange glamour about everything; the inner life of the hospital, which for the first time you are seeing at close quarters, will attract you in a manner which you find hard to explain. You feel you are a power in the land; that on you the success of the institution rests in part—the exact size of the part depending upon your own views—and for the first time you taste the delights of authority. But if you will stay to consider for a moment, to delimit your exact position from an unbiassed standpoint, you must surely be struck with your own comparative cheapness. Your appointment is largely for your own benefit; make the most of it and in return do cheerfully all that is required of you by your seniors. It may irk you, you with the Primary Fellowship behind your back, to answer the beck and call of a man perhaps younger than yourself and with a very ordinary record; you may feel that your talents are ill employed in carrying screens and carting pails. Remember that others have gone through this stage; remember that they were none the worse for it and just a little the better. Do your work cheerfully and to the best of your ability. Learn all you can but do not try and score off those who are in authority over you. The authority is mostly a matter of custom, neither written nor spoken law, but it is good custom and will prevail. And here you must take another warning. You will find that the Staff are always ready to teach you at opportune moments, but it is better for you to leave the decision of opportunity to them lest you err in the direction of importunity. Give the respect that is due to years and attainments, but take heed of yourself and check any tendency to servility which is distasteful alike to them and your fellows, and is, indeed, called by a very ugly name in the vernacular.

And with regard to sport, you will find that there is plenty of opportunity for exercise without any sacrifice of work. Do not imagine that you will do any the better in your professional career by blind grubbing in the library, and, on the other hand, do not expect a long course of attendances at Honor Oak, and nothing else, to get you through your finals. Aim at a nice balance, enjoy your life, and help others to enjoy theirs.

All these matters are matters of experience, not of one man but of many, culled and sheaved for your benefit, that you may start this life of ours knowing what you are, where you are, and where you are likely to get. And so, farewell.

Pass List.

University of Durham. September, 1900.

SECOND EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE.

E. G. Annis, J. W. Caton, C. M. Anthony.

Foreign Bodies in and their Removal from the Ear.

CLINICAL LECTURE BY MR. LAIDLAW PURVES.
July 9th, 1900.

GENTLEMEN, — Before inviting your special attention to a subject of great importance to the practitioner—Foreign Bodies in and their Removal from the Ear,—let me very briefly remind you of some of the anatomical features of the cavity from which in most cases you desire to remove the body, viz., the external meatus.

The length of the canal is one and a quarter inches, the floor is longer than the roof. The cartilaginous portion—half an inch long—is deficient in the upper and back part, and is there replaced by a strong fibrous tissue. The osseous portion is three-quarters of an inch in length. The inner end is marked by the tympanic groove, except at the upper portion, for the insertion of the membrana tympani. These two portions, cartilaginous and osseous, are joined by flexible connective tissue, so that the position of the cartilaginous portion is easily changed by drawing the auricle backwards and upwards. This connective-tissue junction, with the two or three deep fissures of Santorini, which extend vertically through the cartilaginous canal, allow of considerable motion of the meatus and auricle, favour the straightening of the canal, and admit of an abscess, say, in the parotid, passing from the structures external to the meatus into the canal.

The integument is thin and closely adherent. The hair follicles which sift the air somewhat as it passes in, and have been called the "lashes" of the ear, exist near the external orifice. The sebaceous glands also exist near the external orifice. The ceruminous glands are situated in the dense subdermic tissue of the cartilaginous portion. The most sensitive part of the meatus is about the middle, the portion next the drumhead being less abundantly supplied with nerves.

Functions of External Ear.—

(1) It gathers and carries sonorous vibrations.

(2) It, by its curvature, prevents air passing in straight lines to the membrana tympani, and thus preserves the sensibility of that membrane.

(3) It has a resonating action, strengthening the high tones and deadening the low tones.

(4) It reflects vibrations, but usually there are vibrations which proceed direct to the membrana tympani without having been thus acted upon.

As a clinical observation I would wish you to remember that the volume of the vibrations seems to have little influence, at least not what one would expect on the intensity, as a very small space between a ceruminous plug and the walls of the canal allows of good hearing. This may be partly accounted for by the fact that in conversation it is customary to speak louder than is necessary for hearing purposes only, so that conversation which could be carried on in a whisper is conducted with much greater intensity. From conversation being often carried on through a narrow gap between the cerumen and the wall of the meatus, patients in whom this chink has been suddenly obliterated by some slight addition to the mass already present, or by the addition of water, or other agent, causing a swelling of the already present accumulation, or by the change of the position of the mass in the meatus, are greatly alarmed by the sudden and very complete loss of function for usual conversation. If the obliteration occur gradually in the possessor of a good ear on the other side, he may not discover that audition is being carried on by one organ only, and it is only when by some fortuitous circumstance, such as being spoken to when lying on the healthy ear, or having someone sitting on the blocked side and conversing in a low tone at the dinner table, or the application of the telephone to the deaf ear, that the patient has been suddenly made aware of the fact that the hearing of one ear is much impaired, and he is naturally startled to find, on further examination, that for many purposes the ear is of little use. This causes him to seek advice on the matter, and it is as well for him if the fortuitous circumstance which aroused his fears has arisen shortly after the closure occurred, for if a plug of cerumen be left a long time in the meatus it may cause other symptoms which do not always pass away by its removal.

The results arising from the pressure of foreign bodies are numerous. They may cause reflex phenomena, arising in the course of—

1. The *trigeminus*, such as stinging, heat, and hemicrania on opposite side.

Or in the course of (2) *the vagus*, cough, vomiting, tickling in the throat, expectoration.

Or (3) *general nervous attacks* are sometimes seen—epilepsy, anæsthesia of half of the body, atrophy of the left arm, hemicrania of the opposite side, giddiness.

Or (4) *pain or heaviness* in the head.

5. *Sneezing.*

6. *Tinnitus.*

7. *Deafness.*

The variety of bodies found in the ears of children is almost beyond belief. They are from all divisions of the world, animal, vegetable, mineral, and the variety of means proposed for their removal is also extensive. Much might be said and written on the subject, but I will confine myself to a few practical hints which might serve you in an emergency.

Insects.—In the case of insects passing into the meatus, and disturbing the equanimity of the patient either by the thunder-like noise of their wing movements, the excessive irritation caused by moving against the sensitive membrana tympani causing, at times, a spasmodic contraction of the tensor, or other annoying procedure, a rapid relief is obtained by pouring into the meatus a little oil, and then afterwards clearing out by means of a syringeful of warm water, both oil and insect. It has been proposed to tempt the insect out by placing a piece of apple at the meatal orifice, or to suffocate it with tobacco smoke, and then fill the meatus with water to complete the cure — methods which may recommend themselves to some minds! But I should advise the oil and the syringe. On one thing I would caution you. If an insect be complained of, and although your examination of the meatus does not reveal any such, I would recommend you to syringe the ear, as a very small bug or spider, or other minute animal, may not be detected by light if the intruder be much of the colour of the epidermis, or it may be hidden at the junction of the membrana tympani with the canal, which is seldom if ever fully seen on account of the isthmus of the meatus.

Some of the larvæ, those of the bluebottle type, having obtained a position, adhere by suckers. Where you are unable to remove these by the method above given, you may try the mixing of oil or glycerine with some drops of petroleum, turpentine, or an etherial oil. After allowing such to remain in the ear for a few minutes, you may then use the syringe. One minim of turpentine, or of petroleum, to 3j. of glycerine is recommended. But in the case of maggots, the intruder generally keeps near the air, not passing into the recesses of the meatus, where they cannot be seen. Where the syringe is ineffectual, you can remove them by the forceps. With a sound membrana tympani there should be little difficulty in removing them; but with a discharging ear, which unhappily acts as an inducement to the parent to deposit her progeny in the ear, and where the perforation favours them in assuming a position of security, there may be some perseverance required to extirpate them. If you see black points on the membrane, suspect the presence of some grub in its early stage. Happily, such deposits are not frequent in this country, but they are not uncommon in warm countries, where men sleep out of doors, or are otherwise exposed to the myriads of flies indigenous to the tropics.

I need not enumerate the bodies which have been removed from the ear, but pass to some suggestions which you may find useful for their displacement, and as some of these suggestions may prevent much regret to the surgeon, as well as the patient, I beg to call your special consideration to them. I consider this the more necessary in that it is becoming daily rarer for such cases to be seen by the specialist first. Thirty years ago it was asserted that not more than ten per cent. of such cases were passed on at once to the specialist. To-day I would say that five per cent. is much nearer the mark. To anyone who has not accustomed himself to the use of the aural speculum and mirror, I would say that, being unable to see the body complained of, and having failed to remove it by the syringe and tepid water, pass the case on at once to someone who is able to determine the presence of such a body in the canal. Even syringing may in such cases be disastrous in several ways, as in cases which will be dealt with when we come to speak of affections of the membrana tympani, but in the great majority of the cases the syringe may be safely used.

You must first assure yourself of the presence of a foreign body, for it is by no means unusual to find a patient, or his protector, asserting that there is a foreign body present when it is not so, and I regret to say that cases have occurred in which medical men have attempted to remove such non-existing bodies to the detriment of the patient's membrana tympani and ossicles, or with even still greater disaster. To such a degree of irritability do some patients, especially women, arrive, that, in spite of all your assertions, after repeated examination, of the non-existence of such a body, they persecute you with their superstitious ailment, till, in justice to yourself and to relieve the sufferer, you have to find such a body as she complains of, though you may have had to find it in some other place than her external meatus. I recommend you, therefore, first, to determine the presence of the foreign body, if possible, by seeing it. Determine, if you can, its size, its form, its consistency by the probe, if it be hard or soft, its position and what it is, which last

is often to be effected by getting from the parent a bead, bean, pea, or similar article, with which the child was playing when he or she first complained of the ear. Determine if you can move it by means of a strong probe, or blunt hook.

As to the removal of such, remember that peas, stones, beads, &c., may all remain in the ear for years without causing irritation of any kind, if left alone, and unless it be a body which will swell, or have a cutting edge, it can be left for a time. If the canal be inflamed by attempts which have been made to extract the body before the patient has been brought to you, you should, if you can, allay the inflammation by rest and leeches, and so again restore the lumen of the meatus, and, if possible, obtain a view of the body, for this I again impress upon you is of the greatest importance. If the body move about easily, as in the case of shot, it may be sometimes shaken out by inclining the head to the side of the affected ear, or by a sharp percussion with the one hand on the other laid over the opposite ear.

The syringe and the persevering injection of warm water therewith is the method which is by far the most successful, and entails the least danger. Happily two-thirds at least of the foreign bodies found in the ear will be removed by a strong injection of warm water. If the body be a heavy one you may facilitate its ejection by having the ear placed in a downward position while injecting, but this is rarely required, and the only advice I will give you is to straighten the usually tortuous canal by pulling the auricle upwards and backwards, and see that the water gets behind the body, so that the pressure of the column of water is expended upon the inner side of the body to be removed, and drives it outwards. In most cases this is easily effected, as it is rare that a body so closely fills the canal that water does not get beyond it by injection. In cases where the occlusion is complete you may find considerable difficulty in making a passage, and you can easily understand that if you drive your column of water at a body which moves in front of it you may readily cause great damage by forcing it against a sensitive membrana tympani, pushing it through an already ruptured membrane, or causing traumatic rupture through which the body passes.

It is advisable, therefore, before syringing, to see that the body does not entirely occlude the canal, and this is still more important if the body be a hard one capable of injuring such soft structures as those lining the external meatus. Syringing is contra-indicated in the case of foreign bodies, if the body present a concavity towards you, as in the case of the ivory head of a pencil, a very usual foreign body to find in the meatus, from the custom men have of allaying some irritation they may experience in the meatus by inserting the pencil head. It is also contra-indicated in cases of perforation of the drumhead, as it is apt to cause great dizziness and as the fluid escapes by the Eustachian tube the pressure outwards on the foreign body is lessened. It is contra-indicated when the occlusion of the meatus by the foreign body is complete. If the occlusion be great you may try to change the position of the foreign body by means of a probe, or a blunt hook. This failing, you may endeavour to make a tunnel, either at the upper side of the body, pressing the probe between the body and the roof of the meatus, or tunnelling through the body itself. But if you be able to make any impression upon it by such methods, you will be able to pass into it hooks, sharp or blunt, such as I show you here (produced), passing them by pressing the flat side firmly against the meatal wall, and taking care to turn the sharp or blunted point of the hook towards the body, when you think you can insert the point into the body, or have got it beyond the body sufficiently to have a purchase upon it for removal. To avoid making the mistake of inserting the point of the hook into the sides of the canal, you should have the handle of the hook serrated on the same side as that to which the hook points. You can fix the body with a hook and then use other instruments to grasp or cut.

One anatomical point worth remembering in the case of trying to remove a body lying close up to the drumhead, is, that the membrana tympani is more distant from the external orifice at its antero-inferior periphery than at its postero-superior, and that you can accordingly pass your hook along the antero-inferior wall of the meatus further, without pressing against the drumhead, than on the opposite wall. When a body is too smooth and hard to give the forceps a grip, or to allow of the insertion of a hook, dipping a camel-hair pencil in glue, and keeping it in contact with the body till the glue hardens, may effect a purchase sufficient to enable you to remove it. Before using the glue you must dry the body thoroughly and see that there is no secretion present to prevent the glue drying. Birdlime has been praised. Cement is better for pebbles than glue. If a vegetable substance be found in the

meatus, and vegetable substance such as peas and beans are not at all unusual, you should not inject fluid unless you have time to effect the removal at that sitting, or within a short time, as if you find that you are unable to remove it by the syringe, the substance swells so greatly that unpleasant and even dangerous symptoms may arise, and the difficulty of removal is greatly increased. Should you, however, have attempted the removal of a body capable of swelling by means of the injections employed, and failed, the meatus ought to be filled with alcohol, which will to some extent prevent the enlargement. It has been proposed, to prevent such swelling, in the case of peas, beans, and such like which often present great difficulty in their removal, to syringe with oil instead of water.

I need not describe to you the numerous instruments and methods which have been proposed, besides those I have mentioned, to remove foreign bodies. They are as numerous as the various bodies themselves, but I will merely mention the galvano-cautery, injections through the Eustachian tube, the polypus snare, the trephine, the corkscrew, the narrow scissors, the narrow knife, forceps of numerous patterns, a roughened match for woolly or hairy bodies, hanging the patient by the heels, to show the difficulty that many have found in removing such. Cases do arise in which your ingenuity and perseverance will be exercised in extracting the body without damaging the easily ruptured membrane; but with the syringe, probe, hook and forceps, you will very rarely indeed fail.

In operating, proceed slowly in most cases rather than by one great effort, as long as you are at all doubtful of the body and its position. As long as you can break it down, continue to do so till the mass is easily removed. The exception to this occurs when a hard body has been firmly wedged into the osseous tissue; when, having determined its position, and succeeded in getting a firm hold, you extract with forceps.

The results of unskilful interference in such cases are numerous and serious, as meningitis, cerebral abscess, erosion of the carotid, caries of the tympanitic cavity, and removal of the ossicles, have all arisen therefrom.

The following rules may be of use to you. Operate at once if the chances of removal are favourable, if there be persistent cough, if threatening symptoms be present, if the foreign body be in the tympanic cavity, so that you may prevent purulent formation and thereby the danger of meningeal troubles.

Delay attempting to remove a body if the meatus be closed by swelling of its walls, and no damage be feared, and allay the swelling by Lister's apparatus, insufflation of boric powder, injections of a spiritous solution of boric acid, leeches, rest.

As I consider the knowledge of the principles of treatment of foreign bodies in the ear of great importance to the student and general practitioner, and hope that such knowledge may save pain both to patient and practitioner, I briefly recapitulate the rules already given.

1. See the body; make sure that there is a foreign body present. This, as a rule, is easily done where there has not been previous interference with the ear, or inflammation.

2. Determine what the body is, if possible. Obtain a sample of the body supposed to be in the ear, if one can be found.

3. Remember that a body which will not swell, and has no cutting edge, will generally remain without causing any urgent symptoms.

4. Seeing the body, determine by a probe its size, form, consistency, position, and if it be movable. If easily moved, concussion with a downward position of the ear will often remove it.

5. Warm water injection is the best of all methods for removing foreign bodies.

6. If it be a vegetable substance, do not inject fluid unless you have time to extract the body either at one operation or shortly afterwards.

7. Injection failing, which is rare, proceed to remove by other methods, or pass the patient on at once to a special surgeon.

8. To attempt the extraction by forceps, hooks, etc., of a substance which you cannot see is highly dangerous.

9. In children, if you have failed to remove the body by the syringe, before using other instruments, give an anæsthetic.

Papers by Guy's Men.

With Dr. Savage at Bethlem Royal Hospital.—*Clinical Journal*, September 19th.

Some Notes on the Campaign in August. By A. D. Fripp, M.S., F.R.C.S.—*Lancet*, 22nd September.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Lectures* for Sessions 1900–1901.

WINTER SESSION. OCTOBER—MARCH.

†	LECTURERS.		DAYS.					
Anatomy (1st & 2nd)	Mr. Lane and Mr. Dunn	9	—	Tu	W	Th	Fri	—
Microscopical Pathology (3rd) ...	Mr. G. B. Smith and Mr. Pakes ...	9	—	Tu	—	—	Fri	—
Pathological Classes (3rd & 4th)	Dr. Fawcett and Mr. Fripp	9.15	—	—	W	Th	—	Sat
Bacteriology (Oct. & Nov.) (4th)	Dr. Washbourn and Mr. Pakes ...	4	M	Tu	—	—	Fri	—
Practical Obstetrics (3rd & 4th)	Mr. Targett (Oct.)	—	—	Tu	—	—	—	—
Chemical Physiology (Jan.) (2nd)	Dr. Pembrey, Dr. Beddard & Mr. Spriggs	11	—	—	—	—	—	Sat
Biology and Botany (pre. sci.)...	Dr. Stevens	2	—	—	W	—	Fri	—
Chemistry (1st and pre. sci.) ...	Mr. Groves...	12.15	—	Tu	—	Th	—	—
Practical Chemistry	Mr. Wade and Mr. Richmond	10-12	—	Tu	—	Th	—	—
Advanced Practical Physiology (3rd)	Dr. Pembrey	11	M	—	W	—	—	—
Practical Medicine (3rd) ...	Dr. Cleveland	12	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Professor Reinold and Mr. Wade ...	12	M	—	—	—	Fri (2)	—
Chemical Physics (1st)	Professor Reinold	2	—	—	—	—	Fri	—
Practical Surgery (3rd)	Mr. McGavin	12	—	—	W	—	Fri	—
Physiology (2nd)	Dr. Washbourn and Dr. Pembrey ...	10	M	—	W	—	—	Sat
Clinical Medicine (3rd & 4th) ...	The Physicians	1	—	—	—	—	—	Sat
Surgery (3rd)	Mr. Howse and Mr. Lucas	1.30	—	Tu	—	Th	Fri	—
Clinical Surgery (3rd & 4th) ...	The Surgeons	1.30	—	—	W	—	—	—
Elementary Biology (1st) ...	Dr. Stevens and Mr. Swan	2	M	—	—	Th	—	—
Mental Physiology (Oct. & Nov.) (3rd & 4th)	Dr. Savage and Dr. Hyslop	2	M	Tu	—	Th	—	—
Morbid Anatomy (3rd & 4th) ...	Dr. Fawcett and Dr. Bryant	2	M	Tu	W	Th	Fri	Sat
Medicine (3rd)	Dr. Taylor and Dr. Hale White ...	4	M	—	W (3)	—	Fri	—
Ophthalmic Surgery (Jan.) (4th)	Mr. Higgins	3	—	—	W	—	—	—
Public Health (Jan.) (4th) ...	Dr. Sykes	4	M	—	—	—	Fri	—
Dental Surgery and Pathology...	Mr. Newland-Pedley	4	—	—	—	Th	—	—
Metallurgy	Mr. Groves	4	M	—	—	—	—	—
Practical Dental Metallurgy ...	Mr. Hopson (Jan.)	3.30	—	Tu	—	—	—	—
Dental Anatomy & Physiology...	Mr. Maggs	4.30	—	—	W	—	—	—
Dental Mechanics	Mr. Wynne Rouw (Oct.–Dec.)	4	—	Tu	—	—	—	—
Practical Dental Mechanics ...	Mr. Pillin (Jan.)	2.30	—	—	—	—	Fri	—

SUMMER SESSION. MAY—JULY.

†	LECTURERS.		DAYS.					
Medical Jurisprudence (3rd & 4th)	Dr. Stevenson	9.45	—	—	W	—	Fri	—
Midwifery (3rd)	Dr. Galabin and Dr. Horrocks ...	9	—	Tu	W	Th	—	—
Diseases of Women	Dr. Galabin	9	—	—	—	—	Fri	—
Pathology (3rd)	Dr. Pitt	9	—	—	—	—	—	Sat
Mental Diseases (3rd)	Dr. Savage	9.15	—	Tu	—	—	—	—
Microscopical Pathology (3rd) ...	Mr. G. B. Smith and Mr. Pakes ...	9	—	Tu	—	—	Fri	—
Bacteriology (May & June) (4th)	Dr. Washbourn	9.30	M	Tu	—	—	Fri	—
Practical Obstetrics (3rd) ...	Mr. Targett	4	—	Tu	—	—	—	—
Biology and Botany (pre. sci.) ...	Dr. Stevens	2	—	—	W	—	Fri	—
Histology (1st)	Dr. Pembrey, Dr. Beddard and Dr. Spriggs	9.30-12	M	—	W	—	Fri	—
Practical Medicine (3rd) ...	Dr. Cleveland	12	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Professor Reinold and Mr. Wade ...	12	M	—	—	—	Fri (2)	—
Clinical Medicine (3rd & 4th) ...	The Assistant Physicians	1.30	—	—	W	—	—	—
Clinical Surgery (3rd & 4th) ...	The Assistant Surgeons	1.15	—	—	—	—	Fri	—
Clinical Gynæcology (3rd) ...	Dr. Galabin	1.30	—	Tu	—	—	—	—
Morbid Anatomy (3rd & 4th) ...	Dr. Bryant and Dr. Fawcett	2	M	Tu	W	Th	Fri	Sat
Materia Medica (2nd)	Dr. Perry	4	M	—	W(3)	—	Fri	—
Operative Dental Surgery ...	Mr. Badcock	9	—	—	—	—	—	Sat

* No effort has been made to include the many demonstrations or practical work.
† The numbers in this column refer to the years in which this course should be attended.

The Sciences.

ANATOMY AND THE DISSECTING ROOM.

How to begin Work.

THE first working day spent at Guy's Hospital is always a memorable event. There is a feeling of strangeness, which is quite natural. We are but vaguely conscious of what is to be done, and blissfully indifferent how to set about it The very names of the subjects we have been told to learn convey no meaning, and the school buildings, with their various class-rooms and theatres, are an unexplored country through which we travel as in a maze.

For the help of the new men, it is proposed to give such instructions as they may need in beginning the work of their first winter session at Guy's. It will be assumed that they have already decided what the general course of their study is to be, that is briefly, whether they are going in for the Preliminary Scientific Examination of the London University or not. Information on these matters is readily obtained at the medical school office, and any student who is not clear in his mind as to the examination he has to prepare for, should read carefully page 70 in the green book.

After the first few days men soon become familiar with the work, and learn from one another. But at first they have made no acquaintances, and all around them are strangers alike.

Under the new Five Years' Regulations of the Conjoint Board, the first object of the student (entering for instance in October, 1900) is to pass the examinations in Chemistry and Biology, as failure to complete these by the following March (*i.e.*, 1901) must postpone the date at which the Second Conjoint should be passed (*i.e.*, April, 1902), *vide* par. 6, p. 430, so that students are advised, unless they have passed either one or both of the above subjects, before entering the hospital, or are unusually well versed in the subjects for these examinations, to postpone dissections until one or both (Chemistry and Biology) have been completed.

What follows refers, therefore, only to those who intend to undertake their dissections at once.

Monday, October 1st.—There is no actual work done on this day, but each student should pay his fee, *vide* par. 2, p. 430, for anatomical material in the medical school office, and take the receipt across to the dissecting-room and present it to the demonstrators. He should then study the red book—which contains the rules of the dissecting-room—and purchase the necessary instruments and the other paraphernalia therein indicated. Any spare time is well spent in learning where the museums, class-rooms, and theatres are situated. The ground plan at the front of the green book will show them at a glance, and serve as a very efficient guide.

Tuesday, October 2nd.—At 9 o'clock in the morning the start is made, and we get our first introduction to the duties of hospital life at a lecture by Mr. Lane in the anatomical theatre, and at one o'clock a demonstration is given by the Senior Demonstrator in the small theatre attached to the dissecting-room, both of which every new student is expected to attend.

To find a "part."

Look down the list of names on white cards which are suspended upon the wall of the dissecting-room opposite each subject or body. Be careful to take the proper side (right or left) which is allotted to you. If you fail to find your name on these cards, make yourself known and report the fact to one of the demonstrators present, who may be recognised by his white coat. The next thing is to obtain a bandage and cloth from the attendant (Hancock), who will be found in a room outside the dissecting-room. With these the "part" must be covered up at once to prevent the skin from drying. If the "part" is a limb, bandage it firmly from the hand or foot upwards as far as the bandage will go, and cover the remainder with a cloth, *but be careful to leave the metal ticket exposed to view.*

The Requisites for Dissection.

The following articles are essential, and must be purchased at once:—

a. Case of instruments. This should contain at least four knives, forceps, scissors, hooks, needle and blowpipe. Price 15s. to 20s., at Messrs. Down Bros., of St. Thomas's Street; or at Messrs. Hills & Co., of Newcomen Street; also from Hancock, the dissecting-room attendant.

b. Books. These are obtainable at Grattan's in the Borough, next door to the post-office. It is advisable to obtain either *Ellis's Demonstrations of Anatomy* (9s. 6d.), or, better, the more expensive *Cunningham's Practical Anatomy* (2 vols. 9s. 6d. each) for use in the dissecting-room, which show how to proceed and what is met with in the course of dissection; *and* one at least of the standard text-books, viz., Gray, Morris, or Quain. The inquirer will hear their merits compared at the introductory lecture and demonstration; if still in doubt he should consult personally one of the demonstrators, and take with him any old text-book he may possess for inspection and advice as to its use.

c. An apron and sleeves for the sake of protection and cleanliness. These are sold by Hancock. Any old coat may be worn under them. Instruments, books, apron and coat must be safely put away in a locker provided for the purpose; the key is obtained by making a deposit of 5s. at the medical school office. During the day hats and coats are kept at a special cloak-room near the dissecting-room.

d. A disarticulated skull and a half skeleton. (*See below*).

With regard to all the necessary articles mentioned above in *a b* and *d*, it is well to point out to the new students that many men who have just completed their anatomical studies may wish to dispose of some of the above articles second-hand, and new students may obtain information about, and details of such things to be bought, from the librarian, Hancock, or the commissionaire, with whom such things are usually lodged.

Before completing any such purchase it is always best to make sure that the books are of the last edition published and that the instruments are reliable, points on which any of the demonstrators will gladly give advice.

How to Dissect.

The instructions given on this point in the text-books are by no means clear to one who has never done any dissecting in his life, and who does not know the meaning of half the scientific words in which the directions are given. He finds quite a new language in use, and no translation of it in the margin. Thus, he is told to "make an incision," instead of "cut"; to "reflect the integument," for "turn back the skin"; "anterior and posterior," instead of "in front and behind." Not a little of the difficulty and dulness attaching to anatomical descriptions depends on the need of a mental translation of the language in which they are written.

To deal fully with the skilful art of dissection is unnecessary here, and we will merely give such short directions as are needful for the work of the first two or three days. The objects of dissection are—firstly, to educate the sense of touch, and to teach the hand and the eye to work together in delicate manipulation; and secondly, to enable the student to see and handle the different structures that he reads about in his books. It is most decidedly not the object of dissection to lay bare the bone in the middle of the "part" in the shortest possible time. That is butchery, not dissection. The following advice, then, may be given.

1. Take your book by which you intend to dissect (Ellis or Cunningham) and read over the pages giving directions for the skin incisions to be made in that particular part you are about to dissect.

2. Cut through the skin along the lines given in the books.

3. Turn back *the skin only*, leaving the fat upon the body. This is done by holding the knife obliquely with its edge towards the skin.

4. Take away the fat carefully without damaging the dense white layer which covers the muscles.

5. Clean the surface of the muscle. To do this make the muscle taut by moving the limb, or pulling on it with hooks; then with the point of the knife clear away everything covering the muscle by working *with* its grain or fibre, *not* across the fibres.

6. Before taking any fresh step in your own dissection get a notion of the arrangement of the parts you are going to expose, either from another man's part, or from the wax model museum preparations. *Most important of all, never remove any structure until you have obtained a good mental picture of it, and have also read in your book the description of it, and have satisfied yourself you know it.*

7. Work very slowly at first. To turn back the skin carefully is quite enough to occupy the first day's work-time.

8. Cover the "part" up with a cloth before leaving it for the night.

The red book containing the rules of the dissecting-room will be found to contain a lot of useful information, which we give in full below, and should be read with care, and then kept always at hand.

Osteology.

Usually considered a very dry subject; hence commonly studied in a stuffy museum after a heavy lunch with—the usual result. Like other branches of anatomy it must be learnt practically—by handling the bone, reading the description of it, and noting the various marks upon it, each one of which has its meaning. In order that the bones may be studied at home as well as at the hospital, it is very important that each student should possess them. Half-sets of osteology, that is, the bones of one side of the body with the spine and head, can be obtained second-hand at a very moderate outlay, and if carefully used they will at the end of the course readily fetch half the original cost, or even more. Some very useful half-sets (second-hand) are to be seen at Messrs. Millikin & Lawley's, 165, Strand, W.C., price 30s. If these are disposed of at the end of the second Conjoint examination for half the price, it follows that the immense advantage of having the bones always at hand while preparing for the examinations is obtainable at the expense of a few shillings.

In selecting a half-set of osteology it is well to have the guidance of a fellow-student who is familiar with them. See that the half-set is complete, and that each bone is of the *same* side. Avoid "the nice white bones," which dealers always charge extra for, and choose the rougher, better marked and dirtier ones. The preparation which makes them white, does away with many of the marks and ridges which have to be studied. With regard to the disarticulated skulls, try the separate bones and see whether they fit into each other properly, as it is not uncommon to find skulls offered for sale, the bones of which have come from different subjects, and hence cannot be articulated.

It may be necessary now that the "Bone" examination has been done away with at the College, to caution men against neglecting the subject during their first year. They will find the second year's work quite heavy enough as it is, and moreover may suffer the mortification of being spun in the hospital Bone examination at the end of the first winter session, if they neglect the bones in their first month's work.

Rules of the Dissecting-room.

1. All first and second year's Students, and all those senior to the second year, who have not passed the Second Conjoint Examination, are expected to attend in the dissecting-room on the first day of the Winter Session, between the hours of 1 and 4 p.m., or on the second day between the hours 10 a.m. and 12 noon. Each student must bring with him a voucher indicating that he has paid the special fee for material, which voucher must be handed to the demonstrator in order that the student's name may be enrolled in the appropriate class list.

2. The fee for material (which should be paid in the medical school office on or before the first day of the Winter Session, between the hours of 10 a.m. and 1 p.m.) is—

For each academic year:—

First Year's Students	25/-
Second Year's Students	
*Student's Senior to the Second Year but not yet through the Second Conjoint Examination	
Students who have passed the Second Conjoint Examination and are now reading for the First F.R.C.S. or Int. M.B. ...	10/6
Students going up for the L.D.S. Examination only	
Students who enter during May (fee for the Summer Session only)	

3. The senior demonstrator (Mr. Fagge) will meet the first year's students on the second day of the Session at 1 p.m., and give them a demonstration to initiate them into the work of the dissecting-room. Immediately after this demonstration parts will be allotted to students.

4. On the following Wednesday the Bone classes, which are held by Mr. Rowlands and Mr. Swan, begin. Every student must purchase a half skeleton and bring to the class the bone or bones which will form the subject of the demonstration. Regular attendance at these classes is compulsory until a student has passed in Elementary Anatomy. Students now beginning their dissections will be allotted either an upper or a lower (arm or leg), and on which of the two each is dissecting will depend which set of bone classes he is to attend. The student allotted an upper will attend until Christmas Mr. Rowlands' Bone classes on the arm and head, while the student dissecting the lower will attend Mr. Swan's classes on the leg, pelvis and thorax, and after Christmas as he is dissecting the alternative part, the student attends the other set of classes.

5. The senior demonstrator will meet the second year's students on the third day of the Session. The Second Conjoint Class demonstrations given by Mr. Rowlands and Mr. Swan begin early in the following week.

6. No student shall be enrolled in the Second Conjoint list or allowed to begin dissecting as a second year's student until he has passed in Elementary Anatomy and in Biology and Chemistry at the First Conjoint Examination.

7. The notice-boards in the dissecting-room should be examined daily throughout the Session. Here will be found class lists, notices of allotment of parts, announcements of vacancies for prosectors, arrangements for examinations, etc., and notices of alterations in standing arrangements. Every student's name should appear in one of these class lists, and any student failing to find his name should at once inform one of the demonstrators.

8. A written examination is held just before the Christmas Vacation. Every first year's student is required to attend and answer the questions on one of the following group:—

(A) The bones and ligaments of the head, and the bones, ligaments and muscles of the upper extremity; or

(B) The bones and ligaments of the spinal column and thorax, and pelvis, and the bones, ligaments and muscles of the lower extremity; or

(C) (*if he is taking the L.S.D. only*) The bones and muscles of the head, and the temporo-maxillary, occipito-atlanto-axoid and cervical joints.

Every second year's student is required to attend and to answer questions on—

The muscles, tendons, bones and ligaments of the whole body; and one of the following groups:—

(α) The entire anatomy of the upper extremity and of the head and neck, including the brain and spinal cord; or

(β) The entire anatomy of the lower extremity and of the abdomen, pelvis and thorax; or

(γ) (*if he is taking the L.D.S. only*) The entire anatomy of the head and neck, including the brain.

9. A written examination (the School Elementary Anatomy Examination) is held at the end of the Winter Session, and this every first year's student who has dissected during the session (except L.D.S.) is required to attend and to answer questions on the muscles, bones, and ligaments of the entire subject. Completion of this examination is regarded as part of the work to be included by each student in his first year, and the marks obtained at the Christmas examination (paragraph 8) are taken into account by the examiners. A similar examination is held in July, October and January for those students who fail to pass in March.

10. The dissection of all parts allotted in October and November must be completed before Christmas, and on the second day after the recess new parts will be allotted, priority being given as far as possible to those students who showed themselves most painstaking in their previous work. A first year's student who, before Christmas, studied sub-division (A) in Rule 8, will now study sub-division (B); but in addition every student should, in this his second part, try to master as much as possible of the vessels, nerves, etc.

11. The senior demonstrator holds classes throughout the Winter and Summer Sessions for (i.) Students preparing for the First F.R.C.S. and M.B. Examinations of the various Universities, including a special course of demonstrations in Embryology; (ii.) Students who, though they have completed their second year, have not yet passed the Second Conjoint Examination.

12. Every student is advised to carry with him when in the dissecting-room and demonstration theatre a pocket note-book and a set of coloured chalks.

* This Fee must be paid by every such Student whether it is his intention to dissect or not.

13. Every week the dissections are examined systematically by the demonstrators, and marks are allotted. The record thus kept of each student's diligence in the dissecting-room is taken into account in subsequently recommending to appointments in the wards.

14. A test examination is held about three weeks before each Second Conjoint Examination. Attendance at this examination is compulsory on all those who wish to present themselves for the Conjoint Examination for the first time; for those, however, who have previously been referred in this examination, three test examinations are held before each of the Conjoint Examinations in January, April and July, as follows:—

a. About two months before examination on the anatomy of the upper and lower.

b. About six weeks before examination on the anatomy of the abdomen and thorax.

c. About three weeks before (coinciding with examination for unreferred students), on the anatomy of the head and neck, including the brain.

Before the October examination the test examination for referred students is the same as for those who have not been referred.

15. During the first Summer Session, a student who entered in October, and has passed the Elementary Anatomy and the Biology of the First Conjoint Examination, should learn the anatomy of the brain, the spinal cord, the heart, the lungs, the larynx and the liver. Demonstrations on these subjects are given by the senior demonstrator in the demonstrating theatre at least once a week during the Summer Session.

16. Particulars of the examinations for the Michael Harris, Arthur Durham and Hilton prizes, and for the prizes for General Proficiency, will be found in the prospectus of the medical school, which may be obtained in the medical school office.

17. About twelve prosectors to the lecturers on Anatomy are appointed annually (and from time to time a prosector to the Royal College of Surgeons of England) from among those students who have shown themselves most diligent in the dissecting-room. Notices inviting applications for these appointments are posted in the dissecting-room.

18. The metal ticket attached to each part must on no account be allowed to come off nor to be covered up by the bandage that each student should apply to his part (if a limb); neglect of this rule renders the part liable to be forfeited. Apron and sleeves (2s. 6d.), bandages, cloths, air-pump, ointment, carbolic lotion, etc., can be obtained from the dissecting-room porter.

19. No muscle, tendon, nerve, artery, or large vein, should be cut through, if by hooking it aside it is possible to reach and clean the parts lying on its deep surface.

20. No limb must be removed from the trunk except by one of the demonstrators or assistant demonstrators, nor in any circumstances must any part of a subject be removed from the dissecting-room.

21. Except when the student responsible for a part is actually at work upon it, each part must rest constantly on the table of the subject to which it belongs. Neglect of this rule renders the part liable to be forfeited. When a student considers he has finished the part, he must report the fact to one of the demonstrators.

22. The subject is divided into five parts on each side:—

1. The Head and Neck.
2. Upper Extremity and Muscles connecting it with the Trunk.
3. Abdomen, with the Perinæum and interior of the Pelvis.
4. Lower Extremity.
5. The Thorax and Spinal Column; the dissection of which is not to commence until the fourteenth working day.

23. Students are not permitted to exchange or dispose of their parts, either before or after the commencement of dissection.

24. Any part, the dissection of which has not been begun within twenty-four hours from the time when the body is placed in the dissecting-room, is liable to forfeiture. If a student is unable to continue the dissection of the part which he has already begun, he must give notice *in writing* to one of the demonstrators, who will make arrangements for its disposal. The demonstrators will also dispose of any part, the dissection of which has been discontinued without their sanction for more than two working days.

25. The subject when brought in will be placed in the supine position, and will so remain during nine working days. On the tenth day a majority of the students engaged upon it, and on the fourteenth day any one of them, may have it turned into the prone position. Five days later it may, if the majority so desire, be turned back again; and after six days in the prone position any one of the dissectors may have it turned back. The time for the dissection of the perinæum is before 11 a.m. on the first ten days, and neither for this purpose nor for any other must the subject be turned out of the position indicated in this rule.

26. The dissecting-room is open from 9 a.m. till 4.30 p.m., except on Saturdays, when it is closed at 2 p.m.

27. On applying at the medical office a locker may be obtained for a deposit of five shillings (which will be returned when the key is given up, provided that the locker is uninjured).

DENTAL STUDENTS.

A dental student, on entry, must pay the fee (10s. 6d.) for material at the medical school office, on October 1st, between 10 a.m. and 1 p.m., so that a part may be allotted to him at the earliest opportunity. He should

obtain a copy of the rules of the dissecting-room, and study those paragraphs which specially concern him. He should be careful not to miss the demonstration given by Mr. Fagge to first year's students, on Tuesday, October 2nd, at 1 p.m.

Special classes on the bones, ligaments and muscles of the head and neck are held for first year's dental students by Mr. Rowlands, in the dissecting-room theatre on Wednesday, at 3.30 p.m. throughout the winter session (beginning on October 10th).

During their first winter session dental students entering in October are expected to dissect the head and neck and to study the bones and muscles of the head with the temporo-maxillary and cervical articulations upon which they are examined at the end of the session in which they dissect the part. In addition, they should become acquainted with the main vessels, nerves, and special structures of these regions.

For those dental students entering in May a similar set of classes is held by Mr. Rowlands from May to July on Fridays, at 2.30. These students are also expected to finish their first part (head and neck) during the summer session and are examined on it in July. Failure to satisfy the examiner entails attendance at another set of classes during the winter session.

In their second winter dental students are allotted another head and neck, in which they are expected to dissect, besides the muscles and ligaments again, the vessels, nerves and other soft parts, and also to acquaint themselves with the anatomy of all the special regions of this part, *e.g.*, the orbit, mouth, pharynx, etc.

Mr. Rowlands holds anatomy classes for these students, throughout the winter session, in the dissecting-room theatre, on Thursday, at 12.30 p.m., and a test examination is held on the work at the completion of the dissection and the course of demonstrations. It will be agreed that the second dissection is even more important than the first, and it is well to realize that, as the work done by each man is noted and marked every week by Mr. Rowlands, and men are only signed up for the necessary session's work when these marks are satisfactory, that careful and conscientious dissection, punctual attendance at demonstrations, and industrious reading up of all the work, must be begun as soon as the dental student enters the dissecting-room, and continued until the subject is mastered.

It is very essential that the study of anatomy, physiology, and surgery should be prosecuted energetically from the outset, thus obviating the necessity for "cramming" these subjects when preparing for the final L.D.S. examination. Careful and patient dissection is the easiest way to learn Anatomy. An attempt to "cram" it from books is certain to result in disaster.

C. H. F.

PHYSIOLOGY.

Physiology, which treats of the working of the healthy body, and forms, therefore, the institutes of medicine and the necessary foundation of any rational mode of treatment of the body in disease, differs from its sister subject, Anatomy, in that it requires much greater intellectual efforts for its acquisition, and a more thorough preliminary training for the comprehension of its doctrines. Physiology consists chiefly in the application of the natural laws elicited by the researches of physicists and chemists to the explanation and description of the phenomena occurring in the living body, so that an acquaintance with the chief laws of physics and chemistry forms the necessary basis for the study of physiology. The difficulty and importance of this subject would seem to indicate, in the clearest possible manner, the necessity of pursuing its study throughout the short space of two years, which are devoted to the subjects that are preliminary to the work in the wards. On this account, the student beginning his medical studies in October must give all his energies to getting up his biology in order to pass in it at the earliest possible opportunity, and he may profitably combine with the biology lectures and classes the reading of some elementary work on physiology, such as Huxley's *Elementary Physiology*, or the smaller work on the same subject by Foster and Shore. He is advised to attend the physiology lectures at this time, but cannot be signed up for them.

By the ordinary student the practical study of the subjects included under the heading Physiology is begun in the first summer session. During the whole of this session he must attend the classes in Practical Histology. These are held in the students' histological class-room three times a week; each class lasts two hours, the first half-hour being taken up by a short lecture, in which the tissues to be studied in the following practical work are described. This lecture will be held in the physiological theatre. Students attending this course must provide themselves with a compound microscope,* certain mounting materials (a list of which can be obtained at the office), and with Schäfer's *Essentials of Histology*, which should be carefully studied in the intervals between the classes. The microscope must have two objectives, a $\frac{2}{3}$-inch and a $\frac{1}{6}$-inch, a nose-piece and an indicator fitted to one of the two eye-pieces. The following makers are recommended: Crouch, Zeiss, Ross, Leitz (English agent, Kanthack), Swift. From any of these latter firms a good microscope, with all necessary accessories, can be obtained for about £7; the microscope from inferior makers is worse than useless, and it is essential that the student should buy an instrument which will be of some use to him in future years, when as a practitioner of medicine he desires to examine tumours, urinary sediments, sputum, etc., for purposes of diagnosis.

At the end of the summer session an examination, written and practical, is held in histology. All students who have attended this class must enter for the examination. Only those who pass the examination will be allowed to attend the tutorial classes in physiology held

* The demonstrators will be very pleased to advise any student in the purchase of a microscope. It must be distinctly understood that antiquated instruments, such as those sometimes handed down as an heirloom in a family of doctors, are practically useless.

during the second winter session in preparation for the examinations of the Conjoint Board. Those who fail at this examination will be allowed to enter for a similar examination at the following Christmas, but will not be able to present themselves for the second conjoint under six months from the time at which they passed this examination.

During the first summer session and the first half of the second winter session the student must attend regularly the lectures on physiology held three times a week on Mondays, Wednesdays, and Saturdays at 10 a.m. During the same time those who have passed the histology examination at the end of the previous session must attend the tutorial classes held by one of the demonstrators throughout the session. At the same time he must read up the subjects in some elementary text-book, such as Starling's *Elements of Human Physiology*, or Kirke's *Hand-book of Physiology*.

During the second half of the winter session, *i.e.*, from January to March, students must attend the class in practical chemical physiology, which is held once a week in the physiological chemical class-room. While attending this class, they are recommended to read up the subject in Halliburton's *Essentials of Chemical Physiology*, which is also used as the guide in the practical work.

Students who have been diligent in following this course of studies will be ready to enter for the second Conjoint examination at the end of this session. Shortly before this examination, a test examination is held by the demonstrators in order to judge of the fitness of the candidates. Those who fail to pass the second Conjoint at this time must attend the revision classes held by the demonstrators during the two or three months preceding the July and January examinations of the Conjoint Board.

Certain modifications in this course of studies is necessary for those who are going up for the M.B. of London or other Universities. Having passed their preliminary scientific before entering, they are free of the incubus of biology during their first winter session. They should therefore attend the physiological lectures during this session, at the same time studying the subject in Starling's *Physiology*. In their first summer they attend the histology classes, but should supplement Schäfer's *Essentials of Histology* by reading the fuller accounts of the subject contained in Quain's *Anatomy*. During their second winter, they should attend the class in advanced practical physiology, which is held twice a week, each lesson occupying between two and three hours. During this session they are recommended to read up the subject in Stewart's *Manual of Physiology* and Bunge's *Physiological Chemistry*, using Halliburton's *Essentials of Chemical Physiology* and Brodie's *Essentials of Experimental Physiology* as the guides in the advanced practical physiology. This class should also be attended by candidates for the first F.R.C.S. examination, although in their case attendance may often be profitably postponed until the third winter session. The reading for this examination is similar to that required for the Intermediate M.B. of London.

Those who are desirous of obtaining honours at the Intermediate M.B. should supplement the course of reading already indicated with original papers in the *Journal of Physiology* and with parts of Schäfer's *Text-book of Physiology* and of Gamgee's *Physiological Chemistry*. Such students will also find parts of Foster's *Physiology* extremely useful and suggestive.

Revision classes are held by the demonstrators during the two months preceding the first F.R.C.S. and first M.B. examinations for the special preparation of candidates for these examinations.

List of books recommended :—

FOR COLLEGE MEN.—Schäfer's Essentials of Histology; Starling's Elements of Human Physiology; Halliburton's Essentials of Chemical Physiology.

FOR UNIVERSITY MEN.—Stewart's Manual of Human Physiology; Bunge's Lectures on Physiological Chemistry; Histological and Embryological parts of Quain's Anatomy.

BIOLOGY.

The Course of lectures and demonstrations for the requirements of students preparing for the first Conjoint examination is given in the long room, class room No. 2, at 2 p.m., Wednesdays and Fridays. The practical class will be held immediately after the lecture, and the new student is reminded that it is most important for him to attend both lecture and practical class from the *very first*, to obtain the knowledge in biology requisite for the Conjoint examination. The very closest attention to his work, more especially *in the practical part*, is necessary if the pupil would become familiar with a subject which, seemingly of not much value to him now, will be of no inconsiderable assistance in later work, particularly in the domain of morbid histology and bacteriology.

The first lecture will be given by Dr. Stevens, in the long room, class room No. 2, at 2 p.m., *October 3rd*. For the practical class, the requisites, of which a complete list is given below, must be obtained *beforehand*. We recommend new men, with reference to the purchase of a microscope—perhaps the most important consideration on entering these classes—that it should be deferred until one of the demonstrators has been consulted. We may state that microscopes are not absolutely necessary for the early classes, so that the purchase of one may be safely withheld until full instructions have been received from the demonstrators.

The special course of lectures and demonstrations devoted to the Preliminary Scientific examination of London are held on Wednesdays and Fridays at 10 a.m. The first lecture will be given by Dr. Willey on Wednesday, October 3rd, in the biological class-room, No. 4, on the first floor of the pathological museum block

of buildings. "Pre. Sci." men will require the set of requisites that are notified below.

With regard to this list, we have already referred to the "microscope." In purchasing a "dissecting-case," students must understand that an ordinary (human) anatomical set is *all* that is required. The special "biological set" is by no means necessary for the elementary work required at Guy's, and is, therefore, a needless expense.

REQUISITES FOR THE PRACTICAL BIOLOGY CLASS.

Every student attending these classes must provide himself with a microscope fitted with a double nose-piece. Crouch's student's microscope with $\frac{2}{3}$rds and $\frac{1}{6}$th objectives, two eye-pieces and a double nose-piece, in mahogany case, price about £7 10s., is strongly recommended. It can be obtained from Mr. Crouch himself, or from Maw, Son & Thompson, Aldersgate Street. If a foreign pattern of microscope is preferred, Zeiss's or Leitz's is to be recommended, and can be obtained of Stanley, London Bridge; R. Kanthack, 18, Berners Street, W., or of Baker, 244, High Holborn. These microscopes are slightly more expensive than Crouch's. A cheaper microscope, which will serve the purpose, can be obtained from Messrs. Beck, of Cornhill, if preferred.

It will also be necessary to have the following:—Three small white saucers with flat bottoms; three watch-glasses ground on convex surface; two section lifters; three needles in handles; a pair of microscope scissors (curved on the flat); $\frac{1}{2}$-oz. No. 1 $\frac{3}{4}$-inch cover glasses; a gross of glass slides; a packet of labels; a small piece of soft silk; fine curved forceps; a "Seeker"; an anatomical dissecting case; a razor for cutting sections.

The text-book of Zoology recommended to Preliminary Scientific students is "Practical Zoology," by F. Jeffrey Parker, F.R.S., and W. Newton Parker, Macmillan, 1900. This book covers the practical and theoretical sides of the subject, and will supersede those recommended in the Green Book.

CHEMISTRY AND PHYSICS.

It is impossible to acquire a knowledge of chemistry or physics without personal and practical contact, and Guy's men have, in the new laboratories, unusual facilities for this purpose.

Conjoint men entering now should pass in chemistry and physics next Easter, and should therefore attend the lectures in chemistry from October to March (Mr. Groves Tuesday and Thursday at 12.15), and the lectures on physics from October to Christmas (Prof. Reinold, Friday at 2). They must be prepared to devote a large amount of time to laboratory work. The practical classes are held in the chemical laboratory twice a week (Mr. Wade and Mr. Richmond, Tuesday and Thursday from 10 to 12), but students have access to their benches at all hours, and are advised to make free use of this privilege, if they wish to make satisfactory progress. The first class of the new session will commence at *10 a.m.* on *Tuesday, October 2nd*, when *all Conjoint Students* should attend; the first lecture follows at 12.15. Revision classes are held before the April examination, and special classes for referred candidates before those in January and July; admission to these classes is dependent on the student passing the monthly test examinations in a satisfactory manner.

Conjoint students are not required to study chemistry or physics after passing the first examination, unless they wish to take the diploma in public health, in which case they work for three months at the analysis of water, air, food, etc., in the public health laboratory (Mr. Pakes).

Dental students under the new regulations are required to go through the same course as the Conjoint men, and to pass the first Conjoint examination, but those under the old regulations need only attend the lectures and a three months' practical course (Mr. Richmond, January to March).

Special courses have been arranged for most of the University examinations. Candidates for the Preliminary Scientific (M.B.) examination of the London University attend, during the first half of the winter session, the same chemistry lectures as the Conjoint men, but the physics lectures are specially arranged (Prof. Reinold, Monday at 12, Friday at 2). The Preliminary Scientific class meets for work twice weekly in the chemical laboratory (Mr. Wade and Mr. Richmond, winter and summer, Tuesday and Thursday 10 to 12), and twice weekly in the No. 1 physical laboratory (Mr. Richmond: winter, Tuesday 2 to 4, Friday 3 to 4; summer, Monday and Thursday 2 to 4); *but students are expected to spend all their spare time in one or other of the laboratories.* It cannot be too often or too strongly urged that reading without laboratory work is mere waste of time. Tutorial classes are held weekly in both chemistry and physics, and are supplemented by revision classes during the term preceding each examination, and by monthly test examinations. Students intending to work for Honours in either subject should consult the demonstrators. A new and extended syllabus, both for Honours and for Pass, is now in operation.

Intermediate M.B. men who have just passed the Prel. Sci. should begin to work at organic chemistry not later than next May, or earlier if there is room in the laboratory; men who think of working for Honours, or who intend to take the B.Sc. in chemistry should start at once. The attention of candidates is drawn to the recent radical alterations in the syllabus, and especially to the fact that the practical examination now includes the preparation and recognition of typical organic compounds. The practical class meets twice weekly in the laboratory throughout the year (Mr. Wade: winter, Monday and Thursday 2 to 4; summer, Tuesday and Thursday 9 to 12) and is supplemented by lectures, revision classes, and monthly test examinations. A course of experimental lectures for beginners will commence on October 7th (Mr. Wade, chemical theatre, 10), and will be continued through the winter.

Students intending to present themselves for the Inter. M.B. next July should have worked in the laboratory

for nine months by that time, those who attended the course last summer, for instance, requiring to work for four months this winter and two months again next summer. Candidates for Honours next July should, of course, resume laboratory work at once.

Oxford, Cambridge or Durham students desiring to work at chemistry should communicate with the demonstrators.

The practical knowledge of toxicology required at the degree examinations of the London and other Universities may be obtained at classes held by Mr. Wade and Mr. Richmond during the latter part of the winter and summer sessions. W.

PRACTICAL PHARMACY, MATERIA MEDICA, DISPENSING.

These subjects are taught in the practical pharmacy class at the hospital dispensary, by Mr. Collier. This course meets the requirements of students preparing for the Conjoint examination in practical pharmacy, and the intermediate M.B. Lond. The study of the names, physical characters, and chemical properties of substances used in medicine, and preparations made from them, and the doses in which they may be given, requires some considerable amount of application and exercise of memory. The instruction given in the class is therefore very practical, and every assistance is given to the student by demonstrations, access to materia medica specimens, and *viva voce* examinations, in acquiring a sound knowledge of materia medica. The art of dispensing, the writing of prescriptions, and the methods of prescribing drugs, form also part of the instruction given in the practical pharmacy class. During the year there are three courses of three months each, so that the student can enter at the time most convenient to him.

PHARMACY, PHARMACOLOGY AND THERAPEUTICS.

Lectures are given during the summer session in the anatomical theatre, by Dr. Perry. This course is intended to meet the requirements of students preparing for the third Conjoint examination in pharmacology and therapeutics, for the intermediate M.B. and final M.B. Lond., and the third M.B. Cambridge. C.

MEDICINE.

Medicine lectures are held on Mondays and Fridays, at 4 p.m., and Wednesdays at 3 p.m., in the anatomical theatre, throughout the winter session, by Dr. Taylor and Dr. Hale White. The introductory lecture will be given by Dr. Taylor, on Wednesday, October 3rd, who wil then proceed to discuss "Fever, Contagion and Specific Diseases."

A clinical lecture is delivered every Saturday, at 1 p.m., in the physiological theatre, the first of which will be given by Dr. Pitt, on Saturday, October 6th. These lectures are held at 1 p.m., so as to enable footballers to attend, and they finish in time for them to catch the 2.23 train to Honor Oak Park.

In addition to the above course Dr. Bryant holds revision classes for six weeks before the final Conjoint examinations in January, April, and July, for the benefit of students desirous of presenting themselves for the final examination in Medicine.

THE MEDICAL WARDS.

Clinical instruction in medicine is given in the medical wards to the medical ward clerks and other students who choose to be present, by the physicians, who visit their cases from 2 to 5 p.m., and by the medical registrar in the mornings from 10 a.m. to 1 p.m. There are two male wards, Philip and Stephen, each containing forty beds, and one female ward, Mary, containing fifty beds and six cots. The latter is divided into four divisions, each physician taking one division. Dr. Taylor and Dr. Hale White divide the beds in Philip ward between them, and Dr. Pitt and Dr. Perry those in Stephen ward. On Mondays and Thursdays the wards are visited in the afternoon by all the physicians; on Tuesdays by Dr. Hale White and Dr. Pitt; on Fridays by Dr. Taylor, Dr. Hale White and Dr. Perry; and on Saturdays by Dr. Pitt. The medical registrar sees new cases in all the wards on Monday and Thursday mornings; on Tuesday Dr. Taylor's cases; on Wednesday Dr. Hale White's; on Friday Dr. Pitt's; and on Saturday Dr. Perry's. Thirty-six medical ward clerks are appointed every three months, and are eligible for reappointment at the end of this time for a further period of three months, the extension being given to those who have shown the most care and diligence in the discharge of their duties.

Case-taking. — Reports are made by the medical ward clerks on all the cases admitted to the wards, under the supervision of the medical registrar, who instructs the clerks in the mornings in the method of case-taking and the physical examination of the patients. To each physician is appointed a clinical assistant, who superintends the writing of the reports and helps the clerks in any special examination of blood, urine, etc., which may be necessary.

The reports are written on special sheets, kept for the purpose in each ward, and the name, age, address, etc., of the patient should be carefully filled in, as well as any previous admissions into the hospital. In the latter case the abstract of the old report should be copied into the new report. Details as to how to find an old report will be found posted on one of the cupboards in the medical registrar's room, but if the previous admission was in the current year, reference should be made to the registrar for the report. Ward clerks should always make brief abstracts of the case at the end of the report, and in case of death the post-mortem abstract should be copied in, and when the report is finished it should be handed to the clinical assistant, who eventually sends it to the medical registrar. Where possible it is as well to put in the report what the physician said about the case, and especially his diagnosis, but clinical teaching on the disease in general should not be recorded,

and great care must be taken to report the physician accurately.

Temperatures.—The temperature of the patients must be taken and noted every morning by their respective clerks. Evening temperatures are taken by the clerks in turn; the dates of this duty will be found on the notice-board in the central hall of Mary ward. The temperatures to be taken will be put on a card hanging on the wall in each division.

Classes.—On Thursdays classes are held for all medical ward clerks, at 12.30 o'clock, in the surgical class room, on the methods of medical diagnosis and the explanation of physical signs, etc. During the first six weeks of each three months classes are held in the clinical laboratory for the junior clerks on the practical examination of urines and blood, and the use of the ophthalmoscope, laryngoscope, and other apparatus.

The times of the classes will be found posted in the hall of Mary ward.

The Clinical Laboratory (opposite the lift in the medical buildings) is intended for those investigations which cannot be done in the ward. A microscope and a centrifugal machine, and specials reagents are kept there, and examination of sputum, gastric contents and all quantitative analyses should be done there.

Several special reagents and blood stains are kept by the medical registrar locked up, and can be had from him on application.

Medical Instruments.—A laryngoscope, cyrtometer and instruments for examining blood are kept in Mary ward, and can be had, on application, from the Sister.

Tubes for taking cultivations, and pipettes for holding blood for Widal's serum reaction in typhoid fever, can also be had from the sisters of the wards, but these should not be used except with the help of the clinical assistant or the house-physician.

It is very important that the clerk should find out the result of the investigations made by the bacteriologist and record it in the report.

A few practical hints.—Never lose an opportunity of examining a patient for yourself, and then find out what you ought to have noticed. It is only by constant practice that you can train your senses to appreciate the signs of disease, and without this skill mere book knowledge is valueless. Therefore listen to the normal as well as the abnormal, and get into the way of examining your cases with some method, so that you have an intelligent idea of what you are trying to find out. Although only a few cases are under your immediate care it is not intended that you should limit your observations to these, but you should know well all the cases under your physician, and something about all the interesting ones in the medical wards. To do this, when your own cases have been attended to, you should go round with the registrar, or examine the patients allotted to other clerks, and ask what points of interest there are about each case. Also when your physician is not going round attend someone else's clinical instruction, either in the wards or at out-patients. Above all, remember that many of the patients think you to be a "doctor," and treat them as patients, and not as pathological specimens. You cannot be too gentle in an examination of a patient, nor too considerate for the feelings of a sick person. Remember, too, that though the post-mortem room should not be mentioned before patients, yet it is there that you will learn a great deal of medicine, and for you to know your business thoroughly you should never miss an opportunity of seeing the organs whose condition you have tried to make out during life.

As regards reading, Taylor's or Osler's Medicine are the best books, and at first you should read up your own cases and then others as you come across them. Hutchison and Rainey's Clinical Methods or Gibson and Russell's Outlines of Physical Diagnosis will also help you very much. M. R.

PATHOLOGY.

The large number of courses of instruction in pathology given in the school leads to some uncertainty in the student's mind as to the order and period of the curriculum in which they should be taken. Pathology is one of the few good things of which it is impossible to have too much, and probably the best advice that can be given to a student who has passed his second Conjoint or Intermediate M.B. is to take the instruction in pathology which is offered to him as early and often as possible. Most of the instruction in pathology is given in the early morning, so that it shall clash as little as possible with work in the wards, and it is rarely advisable to postpone attending a course till the time arrives, which many seem to expect but fortunately seldom reach, when ward duties shall be less exacting than they are at first. A man who leaves the dissecting-room in April should begin to attend Dr. Pitt's systematic lectures on pathology in the following summer session (Anatomical theatre, Saturdays at 9) where he will be introduced to the great principles underlying pathological processes, and will learn something of the theories of disease, which will enable him to understand the facts revealed to him in the post-mortem room. He should remember that this course of lectures is not completed in one year, and that if he attends the lectures for three consecutive years he will each time hear different subjects treated of. If it is in the summer session that a student is released from his anatomical studies, he should begin to learn pathology at the winter demonstrations (Dr. Shaw and Mr. Fripp, Monday, Wednesday and Saturday, 9.30, in class-room No. 2). Here he will be introduced to the treasures of the pathological museum. Selected specimens will be brought from the shelves of the museum for his inspection, and the effects of pathological changes upon the various organs of the body will be demonstrated. The subject is roughly divided into medical and surgical pathology, two days a week being devoted to the former and one to the latter. The whole course occupies two years. At the end of each half-hour demonstration on museum preparations, a *vivâ voce* examination is held on

typical recent specimens collected from the post-mortem room and operating theatre.

Valuable as is the instruction afforded by these systematic lectures and demonstrations they must on no account be allowed to take the place of the daily demonstrations of Morbid Anatomy (Dr. Bryant and Dr. Fawcett, 2 p.m.) in the post-mortem room. Here a student gains information on the relative distribution of morbid processes throughout the body, and learns to verify the accuracy of his observations at the bedside. No ward clerk must on any account neglect to follow the fatal cases to the post-mortem room, and throughout a student's career there is probably no more profitable way of spending an afternoon unappropriated to routine duty than in watching post-mortem examinations. It is not always possible to find time to hold the appointment of post-mortem clerk, but whenever it is the appointment should be held. The man who misses the opportunity while he is at the hospital of becoming acquainted with the many difficulties that may be encountered in making a post-mortem is sure to regret it afterwards.

The practical use of the microscope in solely pathological problems should be learnt as early as possible. With this object the course of Microscopical Pathology (Mr. Bellingham Smith and Mr. Pakes, Tuesday and Friday at 9 in the New Histological Laboratory) should be attended in the first winter session after the student gets into the wards. Here he will gain his first instruction in practical Bacteriology, which he will have constant opportunities of making use of in the wards. Here he will also amplify the knowledge he has already acquired, in the course of Normal Histology, of section cutting and staining, and have demonstrated to him the microscopical appearances of tumours and diseased tissues. A man cannot often find time to attend this course more than once, but he should attend it early in his career and work hard to learn enough about technique to enable him to afterwards examine specimens that constantly come in his way while holding senior appointments. Morbid histology and bacteriology are very engrossing studies, and many good men fight shy of them on account of the amount of time they fear they will "waste" over them. But a man of method can generally find a good many spare moments to devote to this work without seriously interfering with his reading, and he who acquires the hobby will find it a useful one to ride when he has accomplished his examinations and is waiting for patients.

BACTERIOLOGY.

The compulsory course in bacteriology forms part of that in microscopical pathology. This year, as last year, the first two months will be occupied with this subject. The rudiments of the science are taught; the methods of staining sputum, pus, etc., to demonstrate bacteria; the methods of collecting of morbid products for bacteriological investigation; in fact the technique of the examinations which can be undertaken in the wards.

Two optional courses are also held. These form part of the course for the D.P.H. Examinations, but may be taken quite independently of that examination.

These begin in October and May respectively, and last for upwards of two months. This course consists of lectures and demonstrations which include the morphology and life-history of the pathogenic germs and the disease to which they give rise; the examination of morbid secretions and excretions, water, air, protozoa, etc.; susceptibility, immunity, etc. The students are instructed in the practical details of media making, culture, staining, etc., and they examine the more common pathogenic and non-pathogenic bacteria. G. B. S.

SURGERY.

Lectures are held three times a week, on Tuesdays, Thursdays and Fridays, in the anatomical theatre, by Mr. Howse (1.30) or Mr. Lucas (9.30). Mr. Howse for the first part will lecture on "General Surgery," commencing on Thursday, October 4th. Clinical lectures are given on Wednesdays, at 1.30 in the anatomical theatre, by the surgeons. The first will probably be given by Mr. Howse, on Wednesday, October 3rd.

Mr. Dunn, six weeks before the final Conjoint examinations in January, April and July will hold "Revision Classes," upon which attendance is voluntary. Only those desiring to present themselves for examination are expected to attend.

Mr. Dunn will hold a course of "Operative Surgery" for final M.B. and Fellowship men in October, of which further notice will be given. The course for the requirements of the Conjoint Board will be held in January, 1900, and the fee of 10s. 6d. should be paid not later than December 18th. Names of students desirous of attending the M.B. course should be left at the medical office *before* the end of September. Mr. Higgens will lecture during January to March on "Ophthalmic Surgery," on Wednesday, at 3 p.m., in the ophthalmic operating theatre. The lectures must be attended after passing the second Conjoint examination before admission to the final Conjoint.

THE SURGICAL WARDS.

In the surgical wards there is a division of labour, and corresponding to this division, the appointments fall into two classes—clerking and dressing. The student's first introduction to clinical work is as a clerk in the surgical wards, and it is not unlikely that he may, on his first entry, be a trifle discouraged. The reasons for this are obvious. Entirely ignorant of surgery and even of the terms in common use, he is at once required to write full accounts of the cases admitted to the wards. He will find, however, that by paying attention to the advice we give him, that his difficulties will be found to be anything but insurmountable.

Being the junior appointment in the hospital, there is a tendency in the minds of some, and a little more than a tendency in the minds of others to belittle the post. This is unjust, and is the result of ignorance of the

real functions of the surgical clerk. What the medical clerk is to the medical side, the surgical clerk is to the surgical side. The post is junior in point of time, but does not necessarily carry with it any stigma of inferiority. Their duties are identical: the preparation of the permanent hospital records of the cases admitted to the wards. What difference there is consists in this: the machinery of the medical side is less complicated than that on the surgical; whereas the whole of the work in the medical wards falls on the clerk, in the surgical wards it has been found advisable to specialise and to separate—for the sake of greater proficiency—the duties of clerking and dressing. This separation has, on the whole, been justified by the results, the chief difficulty being the dependency of the clerk on the dresser for many details of importance. Dressers should, therefore, remember that from them the hospital expects such assistance as will render the reports as complete as they can be made. On the clerk, however, rests the responsibility, and the excellence of his reports is a sure indication of smooth working and mutual assistance in the firm to which he belongs.

The recent appointment of an overseer to each firm of clerks in the person of a clinical assistant in the surgical wards has been of inestimable value, primarily to the clerks, secondarily to the whole firm. The clinical assistant should be the immediate "ear" of all his clerks, to instruct them of their duties in the wards, also relieving the surgical registrar of many details in the filling in omissions of the reports of his firm.

We do not wish to exalt the clerk unduly, but to insist merely that in his work the same care and attention to detail, the same knowledge of surgery and human nature are as necessary as in other appointments. Let him bear in mind that to him is given by the hospital the task of keeping its records. These are bound and kept, and by his work thus perpetually in evidence a man is judged. Bad reports are a lasting disgrace; good reports a lasting honour. The importance of good careful work by the clerks cannot be over-estimated. In the nature of things it cannot be perfect, but it must be as perfect as he can make it. By his first work in the wards he will be judged, and he will find that it is very hard to live down a bad clerkship. At the same time that he bears in mind the difficulties and responsibilities of his post, he should remember that he is a junior, and that any assistance he can lend his seniors should be offered ungrudgingly, and in return for this he will undoubtedly meet with that consolation and help in his work which is so necessary. There is no loss of dignity sustained in carrying screens to patients, or in the thousand and one small opportunities which present themselves of helping the other workers in the wards.

To the dressers we would submit that the performance of dressing is no part of the clerk's duty, and that it is no kindness to him to request him to undertake what he cannot from his position with good grace refuse, and what nevertheless he is unfitted to do.

The work of the firm, as a whole, should be the interest of each individual member of it. Pride should be taken not only in its splinting and dressing, but also in its reporting. A good house-surgeon and a good dresser will see that the reports are not below the level of those of other firms, for as they represent the work of the firm the individual members should see that they give a fair and accurate idea of that work. The clerk, aided by the clinical assistant, from this point of view is to be regarded as the mouthpiece of the firm to succeeding generations, The firm should see that he represents it fairly.

The clerk, as soon as he is appointed, should find out from the surgical registrar to whom he is appointed. A few days before taking over the work he should learn from his predecessor what he can about the cases he is to take charge of, so that the work may be continued as nearly as possible without a break. At the present time there is an entire change of clerks every three months, but in the way indicated above, the break in the work may be obviated to some extent. He should learn quickly to take accurate temperatures, and pulse and respiration rates, and test urine, for without any exception the temperature, pulse and respiration rates, and condition of the urine must be included in the notes of every case on admission. The surgical registrar sees every new case with the clerk on the morning after admission, when he expects a history of every case to be ready. This, if vague, is useless. All symptoms should be set down in exact order, with the dates of their appearance. The exactness in detail is of the highest importance, and is a measure of the care with which the clerk has done his work.

He should have a note-book, and should put down in it everything about the case that he can obtain from the surgeon, house-surgeon, clinical assistant, and dresser. This should be copied into the report as soon as possible. We would impress on each clerk the value of seeing everything done by the dressers or house-surgeons—the operations, putting up fractures, especially when done at night in take-in week, and this should apply to manipulations on every case under the surgeon, and not only to the cases which the individual clerk has to report—as much may be learnt in this way which otherwise can only later be gathered with much greater effort.

A new departure was made two years ago in the practical surgery classes, which are in the hands of the surgical registrar, who gives four courses a year, each beginning on the appointment of the new surgical ward clerks, and especially designed for their instruction in all matters relating to that appointment.

Lists of the duties appertaining to each appointment are supplied to the students, and these are to be carefully followed out. The hospital not only expects this, but insists on it. We have laid stress so far on the appointment of surgical ward clerk, as it is the first post that the student holds, and because he is so often quite unaware of the objects of the appointment.

He will in time become a dresser, and will by that time have learnt the traditions that underlie his office.

He should, before accepting office, have acquired most thoroughly the principles of aseptic surgery, and, on no account, ever depart from them subsequently. Let soap and water be his sheet anchor.

The surgical wards are visited every day by the surgeons and assistant surgeons at 1.45. Tuesdays and Fridays are reserved for operations, notice of which has been posted in the colonnade. The surgeons are assisted at the operations by the dressers, and no others should stand about the well of the theatre, the only exception being the particular ward clerk to the case. With due diffidence we should like to hint that the front seats reserved for the staff and for visitors were never intended to be used as a footstool. The habit of sitting perched along the front rail is one of recent growth only, and in the interest of the patient, the operator, and those watching the operation is to be deprecated.

Although we believe there is no rule which prevents freshmen attending operations and clinical demonstrations, we would point out that such a course of action is useless to them, and is not encouraged by the authorities.

Finally, we should like to repeat that although specialization has provided a clerk responsible for the drawing up of the hospital records, yet as this report is an account of the work performed by the firm as a whole, it touches the honour of everyone in it that the report should be an accurate statement of the work done. The firm should be considered the entity, each separate member of which fulfils his own function, each at the same time being dependent on the others for the smooth, even working of the whole. S. R.

DAYS AND HOURS OF ATTENDANCE ON HOSPITAL PRACTICE.

Accidents and urgent cases of all kinds are admitted by the St. Thomas's Street entrance at any time of the day or night.

THE WARDS.

Medical Wards.—Dr. Taylor (1.30), Mondays, Thursdays, and Fridays. Dr. Hale White (1.30), Mondays, Tuesdays, Thursdays, and Fridays. Dr. Pitt (1.30), Mondays, Tuesdays, Thursdays, and Fridays. Dr. Perry (1.30), Mondays, Thursdays, and Fridays.

Surgical Wards.—Mr. Howse (1.30), Wednesdays and Saturdays. Mr. Lucas (1.30), Mondays and Thursdays. Mr. Golding-Bird (1.30), Mondays and Thursdays. Mr. Jacobson, Mondays and Thursdays. Operations (1.30), Tuesdays and Fridays.

Obstetric Ward.—Dr. Galabin (1.30), Mondays and Thursdays. Dr. Horrocks (1.30), Tuesdays and Fridays.

Ophthalmic.—Mr. Higgens (1.30), Fridays. Mr. Brailey (1.30), Tuesdays. Operations (1.30), Mondays and Thursdays.

THE OUT-PATIENT DEPARTMENT.

The days and hours of attendance in the Out-Patient Department of the hospital are as follows:—

Medical Cases.—Dr. Shaw (12.30), Fridays. Dr. Washbourn (12.30), Wednesdays. Dr. Bryant (12.30) Mondays. Dr. Fawcett (12.30), Thursdays.

Surgical Cases.—Mr. Symonds (12.30), Thursdays. Mr. Lane (12.30), Mondays. Mr. Dunn (12.30), Wednesdays. Mr. Fripp (12.30), Saturdays.

Obstetric. — Mr. Targett (12.30), Thursdays and Saturdays.

Ophthalmic. — Mr. Higgens (1.30), Mondays. Mr. Brailey (1.30), Tuesdays and Fridays.

Dental.—The Dental Staff (9), every week-day.

Aural.—Mr. Purves (1), Tuesdays.

Skin.—Dr. Perry (1), Tuesdays.

Throat.—Mr. Symonds (2), Fridays.

Electricity. —Dr. Bryant, Wednesdays. Men (12 noon). Women and children (3 p.m.).

DENTAL SCHOOL.

The dental student is supplied at the medical office with the Prospectus, Standing Orders, Notes on Probationary Work, List of Instruments, Calendar, and Clubs' Union Book.

If these pamphlets are carefully perused the student will become well acquainted with the general arrangements of the school, and the scope of the work upon which he will be engaged during his studentship.

It will first be necessary for him to purchase his instruments at one of the dental depôts, and to satisfy himself that he has been supplied with all of those described in the hospital list.

Probationary work upon the phantom head will occupy the freshman's time for about two months. This operative course is conducted by the staff demonstrators, and it is very comprehensive, as it includes most of the conservative operations that the student will subsequently perform on patients, namely, gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. If the manipulations upon the dummy are done in a thoroughly sound manner, a capital ground work of operative dentistry will be acquired. It may be mentioned in passing that too much stress can scarcely be laid upon the necessity of becoming an expert operator, for the public are not slow to appreciate the highest manipulative skill.

The regulations of the Royal College of Surgeons of England requires that dental students, who registered on and after January 1st, 1897, shall pass two professional examinations for the dental license. At the first professional examination a certificate must be produced *inter alia*, of having manufactured and adjusted six dentures and six crowns.

Inasmuch as it is recommended at Guy's that this examination be passed during the month of May, it follows that the first winter session must be largely devoted to dental mechanics, demonstrations, and lectures.

If a student needs help or advice in his work he is recommended to consult the Dean, or any member of the Staff, any one of whom will gladly do what he can for the best interests of the student.

M.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Rugby Football.

DEAR SIR,—I shall be glad if you will allow me to take this opportunity of welcoming new comers to Guy's, and at the same time calling their attention to one or two little football matters which may possibly interest them. For their benefit I may point out that last year we lost the cup in the semi-final, after having held it the two preceding years. This year the cup must be regained, and to this end every footballer must show that keenness which in past years has always been associated with Guy's.

There will be no lack of opportunities for the revealing of latent talent, and no lack of matches, as the fixture-list shows, for the cultivation of known merit. Good football alone is of no avail unless a real interest is shown in the doings of their representatives by every member of this great hospital. In the words of a famous old athlete, "If you can't play you can shout," and the value of sympathetic encouragement cannot be too highly estimated.

One point further I wish to emphasize. The teams are posted at least three days before the match; I should like it to be clearly understood that no scratching can be entertained later than the morning following publication. Late scratchings not only disorganise the XV. in which they occur, but also play havoc with all succeeding ones.

In conclusion, I need hardly mention that any of the officials will be glad at any time to give further information to those desiring it.—Yours, etc.,

H. A. CUTLER (Captain).

Association Football.

DEAR MR. EDITOR,—Now that one continually sees new faces around us the surmise as to who plays football and who does not, is one which naturally passes through our minds. May I point out that all men who play "soccer" have a hearty welcome to Guy's? Special games are arranged so that new men may have fair opportunity of showing what they can do. Notices of these will be posted in the colonnade and smoking-room, as soon as possible. It is hoped that no one who has any experience of the game will absent himself from these trials, as it is a very difficult task, when once the season has started, to discover the men who may thus be overlooked. No hospital has more advantages than Guy's for practice. The ground is one of the best in London and the fare (4d. return to members) is exceptionally cheap. If men will only show their form at the beginning of the season there is no doubt that the team will be as good this year as in previous years,—Yours, etc.,

W. M. ROBSON (Captain).

United Hospitals' Hare and Hounds.

DEAR SIR,—I should be obliged if you would allow me through your columns to give notice to those interested in cross-country running that a meeting will be held at St. Bartholomew's Hospital on October 8th at 5 p.m. The object of the meeting will be to discuss the future of the United Hospitals' Hare and Hounds Club, which for the last two years has received very little support.

It is hoped that the meeting will be well attended, especially by new men just entering Guy's. If you would call attention to this meeting in your editorial column I should feel much indebted.—I am, yours truly,

Guy's Hospital, S.E. RICHARD S. ROPER,
Sept. 25th, 1900. Hon. Sec. U.H.H.&H.

Nursing News.

MATRON'S OFFICE.

On August 22nd, Nurse Candy, Head Nurse in Martha ward, left the hospital on completion of her three years' training. Probationer Whiteman has been appointed Head Nurse in her place.

Nurse M. C. Martyn, who since completing her three years' training has been doing holiday work, left the hospital on September 1st.

On September 1st, Nurse I. Johnston, Head Nurse in Cornelius, left the hospital on completion of her three years' training. Probationer V. Wood, has been appointed to succeed her as Head Nurse in Cornelius.

On September 1st, Nurse Pegler, Head Nurse in Martha ward, left the hospital on completion of her three years' training. Probationer Beard has been appointed to succeed her as Head Nurse in Martha.

On September 3rd, Nurse Boyd, Head Nurse in the Eye wards, left the hospital on completion of her three years' training. Probationer Ramsey has been appointed Head Nurse in her place.

On September 8th, Nurse Reed, Head Nurse in Stephen, left the hospital on completion of her three years' training. Probationer Davison has been appointed to succeed her as Head Nurse in Stephen ward.

Notice.

THE BEANEY PRIZE IN PATHOLOGY (1900).

The above Prize has been awarded to Mr. J. A. Butler.

Passim.

To the many whose acquaintance with the GAZETTE starts with this number, to the future supporters of the hospital traditions and honour, we give a hearty welcome. Everything seems strange to you at first; the hatless, hurrying crowds seem to move with an absorbing fixity of purpose; the little knots of men in that curious colonnade talk with a surprising earnestness in an equally surprising jargon; while a furtive peep into the Front Surgery sends you back aghast with the magnitude of the task before that young man in shirt sleeves. And the upshot of it is that you feel curiously alone in the crowd, that you experience the "awful loneliness of a multitude," and begin to doubt whether your choice of a profession has been wise. But it will be different in a few weeks hence, perhaps even in a few days, and when the strangeness has given place to familiarity, you will begin to feel an affection for your hospital, which every year will make stronger. And you will never know how strong the love has grown until at the end of your course you leave the old walls and say good-bye to the life for ever.

MUCH of this present issue is devoted to the instruction of the novice. The critical reader who has seen year after year the time-worn, but none the less useful, instruction rolling up in the "Students' Number" will doubtless remark on much that is new in the present number. Every detail has been revised, and where necessary, new matter has been added, so that the instructions contained in these pages may be thoroughly reliable. We hope, therefore, that new men will find herein the solution of many of their difficulties, and that the monumental patience of the Medical Office will not be unnecessarily strained. For our own part we should like to remind Freshmen that the GAZETTE is always ready to consider any contributions which may be submitted, guaranteed always by the name of the sender, and that the little box at the front entrance, which must not be mistaken for the front surgery letter-box, has been designed for the reception of such contributions. Manuscripts should be sent in as early as possible, and certainly not later than the Wednesday morning in the week of publication.

IN another column will be found letters from the two football captains, dealing with their especial departments. With the advent of a new century, we should like to see some of the Cups, some of *our* Cups, back again in the Smoking-room, and not the least of these, we should like to see the two Football Cups in their proper homes over the fireplace. Everyone in this hospital desires the same happy consummation, and everyone should do what he can in this direction. The freshman can help by turning out at the trials and letting the football executives see what new stuff is available. There are not too many opportunities for preliminary canters of this kind, and no one should think that his reputation—if he have one—is to stand him instead of an ocular demonstration. Therefore, the keen man, more especially the new-comer, should keep a sharp look out for notices of trial games, and give in his name accordingly.

WE publish in this issue an interesting account by Mr. Manson of his personal experiences with the malarial mosquito. The fact that he was the first man in England to give an experimental dinner to these Italian visitors has proved an immense bait to the daily press, and systematic hunts, conducted by "representatives," have taken place within the walls of this hospital, with Mr. Manson as the quarry. So far he has successfully avoided being run to earth, but he is still haunted with the fear that one day his disguises will be broken down and he will be known to fame under the mutilated wood-cut of some popular murderer. Mr. Manson has shaken off the ill-effects of the inoculation pretty rapidly, and looks little the worse for his experiment. We sincerely hope that he will not suffer in the future for his plucky devotion to the science of medicine.

FOR the third time we remind our readers that the Students' Club Dinner, with Dr. Hale White in the chair, will be held next Monday in the College Hall. Also that the opening sitting of the Physical Society will be held to-day week, and not on the same evening as the dinner. It will be remembered that a couple of years ago Mr. Curtis went on an exploring expedition in Northern Siberia, and it is of his adventures, chiefly ornithological, that he is speaking at the opening meeting of the Society. Mr. Curtis has had some little experience of scientific expeditions, and his address, which will be illustrated with photographic lantern slides, should prove highly interesting. Guy's men intending to be present

at the dinner on Monday should, if they have not already done so, send in their names, with the number of visitors they are introducing, to the Stewardess without delay.

THE QUEEN has been graciously pleased to confer the Royal Red Cross upon Mrs. Drake, (formerly Miss Stowell and Sister in Patience Ward) for her services in British Central Africa. In a private letter home, Mrs. Drake says that Guy's, more than any other hospital, is intimately associated with British Central Africa, for the whole medical and nursing system there owes its origin to Dr. Wordsworth Poole. Mrs. Drake expresses herself in the warmest terms of affection for her old hospital, and states that she consistently wore our uniform while on service.

At a meeting held at King's College on the 19th June last, of representatives of various colleges and institutions concerned in the reorganised University of London, a committee was formed, having power to add to its numbers, to consider the feasability of "establishing a London University Club or Clubs for Athletics and other forms of sport." The general idea was to associate on the model of the older University clubs. Membership would be selective, and limited to internal students of the University, that is, to men (and presumably women) who had matriculated and were members of one of the constituent teaching institutions of the University. The other class of London University student, he who is attached to the University merely for examinational purposes, would not be eligible for membership. Similarly, members of constituent institutions who were not undergraduates or graduates of the University would be equally ineligible. The various members of the provisional committee were asked to give publicity to the scheme.

ON paper the scheme looks reasonable enough, for broadly speaking L.U.C.C. is as rational as C.U.C.C. But examined in detail, the project shews features which make the thing not only improbable, but, humanly speaking, impossible. To begin with, there is no association of kindred interests. In the older Universities the college is the working unit, with its ties of tradition and building. A man is a Trinity man whether he be studying medicine or mathematics; and he has a common sympathy with other Trinity men which builds up his college *esprit*. Hence the University consists of a number of outwardly similar parts, although the internal composition of these parts may vary greatly, all bonded by a common loyalty, and an individual is bound by devotion, firstly to college, and secondly to University, with no appreciable change in intensity. In London, however, each institution deals, generally speaking, with one particular science or art, and is by no means exclusively attended by London University men.

THOSE institutions which have any *esprit-de-corps* are almost, if not entirely, of this nature, and the spirit is fostered both by the School and the Science. This fact has been strikingly demonstrated by the mutual and successful associations of hospitals whose individual members are tied only by the similarity of study, and the traditions of their medical schools. The colleges where medicine is only one of many faculties, are not remarkable for any great athletic individuality, chiefly because of their conflicting components and the lack of any generally recognised external influence. Some of the institutions whose students would be naturally entitled, other things being equal, to membership of this proposed club, are by their very nature incompatible and calculated to disrupt any association however artfully contrived. It remains to be seen what will be the final result of this project; meanwhile we may remark that the committee, as we have it, is chiefly characterized by its weakness.

LATEST news from the Imperial Yeomanry Hospital confirms the report that Dr. Washbourn is still remaining with the hospital. Mr. Fripp should be among us very soon, and will later be followed by some others of the surgical staff. With regard to the dressers, Mr. Greenfield is at present recruiting health down south, and will sail for home shortly. Of the others from this hospital, all are retained on duty at Deelfontein with the exception of Mr. Pearson, who is away on leave at Kokstad, in Griqualand East. Mr. C. B. Sells, whose recovery from typhoid fever we noted in our last issue, is remaining at Deelfontein as a dresser.

WE have received a circular-letter from the Secretary of the United Hospitals' Hare and Hounds Club, calling attention to the General Meeting which is to be held at St. Bartholomew's on October 8th, at five o'clock. Interest in this Club has been gradually but surely waning, and now it is to be debated whether the whole

affair is to be allowed to die out. Guy's is largely responsible for the present deplorable state of affairs, for the Challenge Cup has been so long a resident here that other hospitals have given up all hope of retrieving their fortunes. We hope the Club will not be allowed to die. Guy's men at any rate should do their best to prevent such a calamity, and for the present this best is comprised in attendance at the general meeting. If the Club cease to exist, there will be an inevitable deterioration in the Athletic Club, more especially in the case of the long-distance flat races.

Interest in the tugs-of-war has awakened with tremendous vigour. After numerous scratch performances at odd hours, the Golding-Bird firm met and defeated, with comparative ease, the Howse team. There was a large and enthusiastic audience, which betrayed much partisanship. Then the Lucas team met the Jacobson men, and we have it on the highest authority—no less than that of a member of the winning team—that the physique and pulling powers of the Lucas team were so immeasurably superior to those of their opponents, that the tie practically amounted to a walk over. The final surgical tie was most interesting. After a long and evenly-balanced pull, the Lucas team wore down the Golding-Bird men, and on changing ends repeated the performance with somewhat less difficulty. On the medical side only the Pitt and Perry firms are competing, the latter with seven men. The winner should fall a very easy victim to the phagocytic leucocytes. In future contests we might suggest that the audience should show a little more gallantry and not completely shroud the tug-of-war from spectators in the reserved seats.

The new house appointments are now posted, and, as everyone expected, the Colonies have scored heavily. Congratulations to Messrs. Mullins and Cohen on their elevation to the dignity of H.-S., and to Messrs. Dunstan and Watson on getting House-Physicianships, also to Messrs. T. P. Thomas and W. B. Secretan on appointment to the Front Surgery, Messrs. Brydone, Holmes and Reeve to Assistant Surgeons, and Messrs. Davies and Shufflebotham to the Medical Department. Excitement, however, has not yet died out, for Mr. Shufflebotham has, for private reasons, been forced to resign his appointment as A.H.P., and speculation on the new post now runs rife. Here we think the old proverb of the early bird will be again exemplified.

Attention is called to the Chess Club, which is not as yet affiliated to the Club's Union. This flourishing little concern had quite a successful season last year, and succeeded by the help of draws and scratchings, in holding a quarter of the newly instituted Inter-Hospital Challenge Trophy. With the help of new blood and enthusiasm, and a little luck, perhaps, we may succeed in getting hold of a bit more this year, or even the whole lot. Men interested in chess should communicate with the honorary secretary, Mr. E. Faulks, who will be glad to supply any further information.

Malaria.—An Experiment.

In 1894, Dr. Manson formulated the theory that malaria is transmitted by the mosquito. Having previously proved that the mosquito is the intermediate host of Filaria Sanguinis Hominis, a parasite infesting the human blood, he argued that the hæmatozoon of malaria living under conditions analogous in many respects to the Filaria Sanguinis Hominis is abstracted from the human blood in a similar manner, namely, by the mosquito, and that in the mosquito it undergoes changes necessary for the completion of its life cycle.

Major Ronald Ross, I.M.S., subsequently proved that malaria in birds is transmitted from bird to bird by the mosquito.

Grassi and Bignami confirmed experimentally for human malaria what Ross had proved for avian malaria. Grassi also pointed out that the particular mosquito responsible for the transmission of human malaria belonged to the genus Anopheles.

It was therefore clear to those who had studied the subject that malaria was transmitted from man to man by the mosquito. Although the experiments and observations mentioned above were convincing to those acquainted with the subject, yet the public somewhat ignored them, and those residing in tropical countries were not sufficiently convinced to put their convictions into practice, viz., to protect themselves from mosquito-bite. To bring the matter thoroughly home to laymen Dr. Manson devised the following experiments:—

Experiment 1.—To prove that a healthy man living in a non-malarious country, who had never suffered from malaria, if bitten by infected mosquitos will develop malaria.

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Experiment 2.—To prove that malaria will not be contracted by residents in malarious districts provided they protect themselves from mosquito bites.

I was the subject selected for experiment (1.) I am twenty-three years of age, was born in China, but have

lived in this country since I was three, have never been abroad since, nor in any district in this country reputed to be malarial. I am healthy.

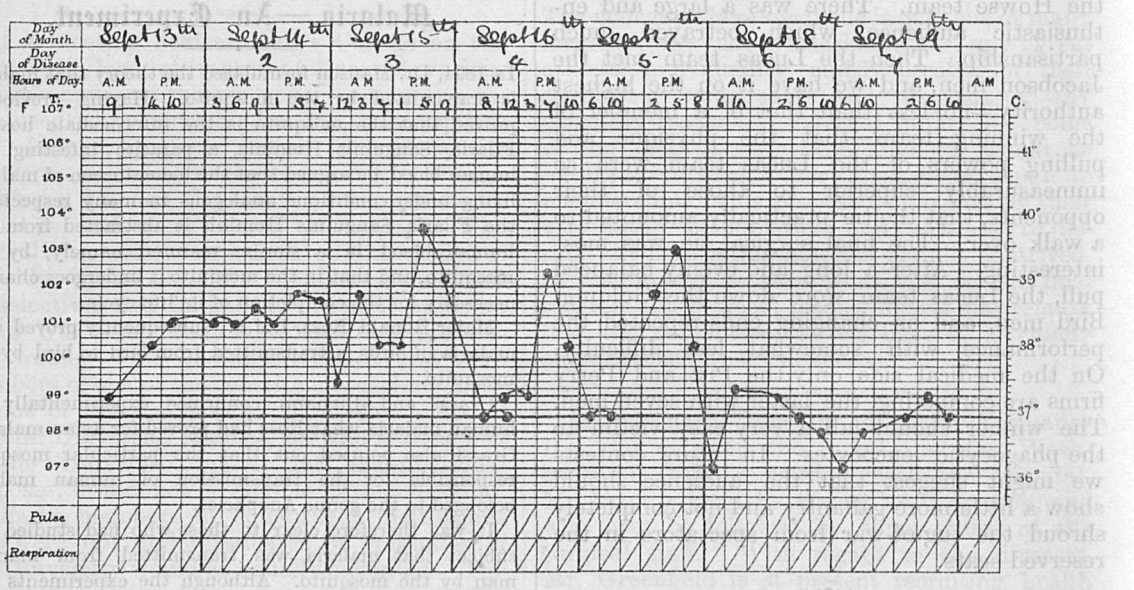
Dr. Bastianelli, of Rome, kindly reared mosquitos from larvæ and fed them on patients suffering from malaria of a benign type as recognised clinically and by the microscope. Through the courtesy of the Foreign Office and the Post-Master General the infected mosquitos arrived in London forty-eight hours after having left Rome and were at once transferred to the London School of Tropical Medicine. They were brought over in gauze netting cages devised by Dr. Sambon, the cages being kept at a suitable temperature in a specially constructed chamber.

The mosquitos were fed either by introducing the hand into Dr. Sambon's cages or by allowing them to bite through the gauze netting. In all there have been three consignments. The following are my notes of the experiment.

The third and last consignment arrived on September 10th, having been infected from a patient suffering from a simple tertian infection with very few parasites in his blood. They were about fifty in number. Twenty-five bit me on September 10th and ten on September 12th.

I kept in good health till September 13th. On September 13th I rose feeling languid and out of sorts, with a temperature of 99° F. By midday I was feeling chilly and inclined to yawn. At 4.30 p.m. I went to bed with a severe headache, lassitude, pain in the back and bones, a temperature of 101·4°, and feeling cold. Repeated examinations of the blood were made, but failed to reveal the presence of malarial organisms.

September 14th. I slept fairly well but woke at 3 a.m. with slight sweating and a temperature of 101°. During the day the temperature ranged between 101° and 102°. There was complete anorexia in addition to the symptoms of September 13th, viz., headache, lassitude, chilliness, and boneache. Examination of the



The first consignment of mosquitos arrived on July 5th. There were only six of them, they were in poor condition and would not bite me satisfactorily. By July 7th they were all dead.

The second consignment arrived on August 29th. They had been infected in Rome on August 17th, August 20th, and August 23rd, by being fed upon a patient who had numerous benign tertian parasites in his blood. Twelve mosquitos survived the journey. I fed them as follows:—

August 29th. Five mosquitos were fed.
,, 31st. Three mosquitos were fed.
September 2nd. One mosquito was fed.
,, 4th. One mosquito was fed.

They bit my hands and fingers readily. The bites irritated slightly for two or three days.

blood was again negative, though several examinations were made during the day. To relieve headache phenacetin, grs. v., was given at 6 p.m. I perspired profusely during the night.

September 15th. Woke at 7 a.m., having slept indifferently. I felt distinctly better. The temperature was 100·4°. On repeated examinations of the blood by Dr. Manson no malaria parasites were found. About 2 p.m. I commenced to feel slightly chilly. This lasted about an hour. I then became hot and restless. By 4.30 p.m. the temperature was 103·6°. It remained about 103° till 9 p.m., when profuse sweating set in. I am told there was some delirium.

September 16th. I woke at 8 a.m., feeling better. Temperature 98·4°. I made several blood examinations, and found one doubtful tertian parasite. In the after-

noon and evening there was a recurrence of fever, preceded by chilliness and relieved by sweating. The temperature at 7 p.m. was 102·4°.

September 17th. Again felt better in the morning, having slept well the previous night. At 10 a.m. the temperature was 99°. On examining the blood, Dr. Manson found several half-grown benign tertian parasites. During the day many parasites were found, including gametes. Several pigmented leucocytes were also seen. The presence of these parasites was verified by Dr. Manson, Dr. Frederick Taylor, Lieutenant-Colonel Oswald Baker, I.M.S., Dr. Galloway, Mr. Watson Cheyne and Mr. James Cantlie, some of whom saw the blood films prepared.

About 2 p.m. the sensation of chilliness returned. Temperature 101·8°. By 5 p.m. the temperature had reached 103°. There was then profuse sweating. The spleen ached slightly, its edge being felt on deep inspiration. Dr. Frederick Taylor and Mr. Watson Cheyne confirmed the presence of the splenic enlargement. By 9 p.m. the temperature had fallen to 99·2°, and I was feeling better. Quinine grs. 10 was given.

September 18th. Woke after a good night's rest, feeling perfectly well. Temperature 97°. Quinine grs. 10 was taken, and subsequently grs. 5 every eight hours. I continued perfectly well all day. A few three-quarter grown tertian parasites were found during the forenoon and afternoon. They were seen by Dr. Oswald Browne, Dr. Manson and myself. By 10 p.m. the parasites had disappeared, the last being found at 5 p.m.

September 19th. Temperature normal. There was no splenic tenderness nor enlargement. No parasites found in the blood. Appetite returned.

September 25th. There has been no recurrence of malarial symptoms, and I am in normal health. I have been taking quinine, 5 grains every eight hours for the last six days.

From what is known of the incubation period of malaria there can be little doubt that I was infected by the second batch of mosquitos. Assuming this to be true it is interesting to note that these mosquitos had been infected from a double tertian case and that they communicated the same form of malaria.

Experiment 2. Five Europeans, including Dr. Sambon and Dr. Low of the London School of Tropical Medicine, have resided since the beginning of July in a hut specially constructed to exclude mosquitos in the most malarious part of the Roman Campagna. They go about in the surrounding jungles and swamps and mix freely with the inhabitants of the district during the day, but are careful to retire to their mosquito-proof hut before sunset (that is to say, before the mosquito commences to feed) and do not leave it again before sunrise. They have not been bitten by mosquitos, and have not suffered from malaria, whilst the entire population in the neighbourhood, both permanent and migratory, is universally malaria-stricken. These experimenters have taken no quinine.

These experiments conclusively prove that Dr. Manson's hypothesis is correct, and that immunity from malaria can be secured by simple measures which do not materially interfere with business or pleasure. It is hoped that the publicity intentionally given to these experiments may lead to practical application of the mosquito-malaria theory.

P. Thurburn Manson.

With the Army Medical Corps in South Africa.

(By Our Special Correspondent.)

(Published by permission of the Director-General of the Army Medical Service).

Wolvehock Station, O.R.C.,
July 19th.

There is but little to record here for the past fortnight. Things are settling down along the line, and a P.M.O. for lines of communication—Lt.-Col. Dorman, R.A.M.C., formerly P.M.O. of Sir Henry Colville's (9th) Division—has taken over the reins of medical government. Every garrison has its own doctor, either resident or visiting it; and as there is a garrison every ten miles or less along the line, this means a good hole in the medical personnel at the front, especially now, when a large proportion of the field force is actively employed, and when several army officers and civil surgeons have died or been invalided from enteric. Two of the writer's former colleagues, both men of great promise, one from Glasgow, the other an old Bart.'s H.-P., have recently died at Kroonstad—a grievous loss to all who knew them. Fortunately, the epidemic in Bloemfontein and elsewhere is dying with the season.

In the small hospital now established here, with beds for eight and floor accommodation for treble that number, there have been a few cases of fever of all degrees of severity, from the mild attack lasting two or three days to the prolonged fever which ends in obvious typhoid. In the slighter cases the symptoms are just as in the early stages of typhoid, with a rather gradual onset, malaise and lassitude, head-ache and back-ache, and perhaps a slight congestion at the base of the lungs. Typical rose-spots are rare, but they may be masked by the conditions. The temperature is two or three degrees higher in the evening than in the morning. The bowels are usually constipated on admission, but usually become freely open, and in a few cases there have been almost typical enteric stools. In marked cases there are mental dulness and extreme weakness, which continues long after the temperature is normal and other signs have vanished. There is a great tendency to relapse, and in many cases this relapse has taken place within a day or two of the early return to a diet of "rations without meat," that is, soup and biscuit. In other cases it has occurred to men released from prison at Waterval, where

they say they suffered from enteric fever—this, then, at an interval of some weeks.

One case, watched here for three weeks, was that of a healthy Canadian sergeant, who reported sick after three days' malaise with a temperature of 101·2°. In the evening his temperature rose to 103°. Weakness increased, there was slight diarrhœa; but on the 12th day of illness the temperature was normal in the morning, although 101·2° at 6 p.m. On the 15th day the temperature was normal also in the evening: on the 16th eggs were ordered in addition to milk and bovril; on the 17th, rations without meat, as the patient looked the picture of health, feeling only slightly weak. On the 19th day the diarrhœa recurred and the evening temperature rose to 100·4°. The diet was changed, but the temperatures the next day were (normal) 101° and (normal) 101·2°, and the diarrhœa and weakness continued. The patient was sent down to Kroonstad for comfort and good nursing.

Other cases are varients on the same theme, one or two becoming delirious, and even, after their arrival at Kroonstad, losing consciousness; while others shake the illness off in ten days, a week, or even less, and return to duty. In these there is no sign of malarial symptoms or history, and quinine has no obvious effect, except as a "placebo." It is a pity that a proper study of the disease is impossible; but Widal's test is an impossibility and there are no facilities for bacteriological work. Until such a methodic study is made, it is useless for anyone to express an opinion on the identity or distinction of the so-called "enteric" and "simple continued" fevers. Unfortunately such opinions are too frequently expressed and in the most dogmatic terms. It follows that the statistics on these points are valueless, as different General Hospitals and different doctors will classify their cases differently. Nor has any return been made of cases of this "simple continued fever" after inoculation. As these cases will be omitted from the inoculation statistics, the experiment of this war will be incomplete, The writer, like many others, prefers to group all these cases under the simple heading of "fever."

The personnel of one irregular mounted corps is always interesting. Of three troopers of Loch's Horse recently in hospital here, one was the son of a wealthy man of affairs, the second was heir presumptive to a peerage, and the third was an old Guy's man, Steadman, who qualified at the colleges some ten years ago and has wandered all over the world since then.

Civil-Surgeon F. O. Stoehr is in medical charge at Vet River, after a long period in the general hospital at Kimberley.

No. 2 General Hospital from Wynberg and the Irish and Langman hospitals from Bloemfontein have gone up to Pretoria, and No. 6 from Naauwpoort went through yesterday to Johannesburg.

The telegrams referring to the controversy on hospital management are scanty, but the appointment of a committee of enquiry cannot fail to be a good thing. If you ask almost any combatant officer at the front about the administration of the various departments during the war, he will refer to the medical department in terms of unstinted praise. Nearly all the complaints made against it from without can be traced to the lack of transport. This may or may not have been necessary for strategic reasons; but a strong committee of inquiry will bring this fact into prominence and convince the British public at home that for this reason, in sending their soldiers to the war, they cannot provide them with a perfect system of medical treatment as matters stand at present.

It would seem that the complaints levelled against the base hospitals would have been materially modified, if the complainants, instead of rushing into print, had been compelled to see something of the work at the front and its difficulties. On the other hand, it is pitiful to read of men of the highest rank in the profession giving it as their opinion that the medical arrangements, when not interfered with, were perfect.

It is an abuse of the language to apply the term to any work under the conditions with which the British officers of all departments have had to contend in this war. Such an opinion, obviously not accurate, conveys the impression that there is something to be screened. The committee will remove the screen and let the public judge for themselves.

F. E. F.

In Lighter Vein.

A FARCE (IN THREE MONTHS)

ENTITLED

"CHAOS."

(Dedicated without permission to those whom it may concern.)

SCENE—*The Front Surgery.*

DRAMATIS PERSONÆ—*Droves of Dressers, Clots of Clinicals, Armies of A.H.S.'s (save those who are billed in the Colonnade to appear), incidentally, a few Patients.*

(*Enter from private room a dresser wearing a stethoscope and a worried look; he approaches a young-looking A.H.S., who carries a Skinner, and who at the moment is laughing in C Altissimo at—nothing.*)

DRESSER (confidently): I say, I've got a case here I don't quite understand; will you kindly——

YOUNG A.H.S. (becoming serious): Sorry, but I'm not running the front.

DRESSER (surprised): But you were a minute ago!

Y.A.H.S.: Ah, yes, but Z (pointing to a Clinical) is doing so now. Ask him. (Resumes his laugh.)

(*Dresser barges over to Z.*)

DRESSER: I say, I've got a case I want you to see.

Z. (*who has just made a correct diagnosis, and is trying to look as if it were quite an ordinary occurrence*): I'm not running the front, dear boy.

DRESSER: Not! but I was told you were.

CLINICAL: Told wrong, then. Try X. (*Departs to go over his case again.*)

(*Dresser edges diffidently towards X., a portly young gentleman, who holds concurrently all the appointments the hospital has to give, and who is holding forth to an admiring crowd.*)

DRESSER: Oh, please, there——

X.: One moment, my son. (*To his satellites*), Yes, called me out of bed, they did, at three a.m., though I told 'em they might give anything they liked; but its just like women, they——

DRESSER: Look here! come and see a case.

X.: What! me, my son? No-o-o. I've got nothing to do with the front.

DRESSER: Well, for goodness sake, who has?

X.: I don't know, laddie. Pop off!

DRESSER (*despairingly to a clinical in a purple, blue, and green tie*): Are you running this confounded front?

CLINICAL (*cannily*): What's the case?

DRESSER: I think its Dip.

CLINICAL (*remembering a certain Post Pharingeal abscess, edges rapidly off*): No fear.

BOROUGH LADY AT BACK (*in stentorian tones*): No, I ain't going to sign no (*adjective*) book. And I ain't going to (*adjective, adjective*) stop. The kid's been waiting three hours already, you lot of (*adjective—adjective—adjective, etc., fades away into the night*).

(*The official A.H.S. in the Front suddenly appears from Honor Oak, or the Alps, or somewhere.*)

OFFICIAL A.H.S. (*to Dresser*): What the deuce do you let people go out without being treated for, eh! young man?

DRESSER (*collapsing on bench*): —— —— ——. (*Curtain.*)

J. M. B.

Appointments.

CIVIL.

BRODRICK, C. C., L.R.C.P., L.R.C.S. Edin., has been reappointed Medical Officer of Health for Tavistock.

DAVIES, F. W. S., M.R.C.S., L.R.C.P. Lond., has been appointed Honorary Anæsthetist to the Cardiff Infirmary.

GODSON, J. H., M.B., B C. Camb., D.P.H., has been reappointed Medical Officer of Health by the Cheadle and Gatley Urban District Council.

PEARCE, D. A. CHANING, M.D. Lond., B.S., M.R.C.S., has been appointed Medical Officer and Public Vaccinator for the Chartham District of the Bridge Union.

STEINHÆUSER, J. R., M.B., B.S. Lond., L.R.C.P., M.R.C.S., has been re-appointed Medical Officer of Health by the Lewes Town Council.

WRIGHT, G. A., M.B. Oxon., F.R.C.S. Eng., has been appointed Honorary Surgeon to the Manchester Cancer Pavilion and Home.

NAVAL AND MILITARY.

Staff-Surgeon E. P. MONRILYAN, M.B., has been appointed to the *Severn*, and Surgeon H. E. C. FOX, M.B., has been appointed to the *Gladiator*.

Major E. C. HARE, I.M.S., on leave in England, has been recalled to duty owing to the great demands made for the China Expedition.

Civil-Surgeon J. L. A. AYMARD, lately prisoner of war, has arrived at Lorenco Marquez from Nooitgedacht, and will be sent to Durban.

Guy's Hospital Clubs' Union.

THE FORMATION OF THE CLUBS' UNION, by the amalgamation of the various constituent institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the clubs and societies existing at the Hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscriptions, or of a composition fee (see Clubs' Union Blue Book, page 14), to the Clubs' Union, any student of the Hospital can obtain the privilege of membership of the constituent institutions.

THE GROUND OF THE CLUBS' UNION, which is under the control of the council, is situated close to Honor Oak Park station, on the London, Brighton and South Coast Railway, and to the Crofton Park station on the London, Chatham and Dover Railway. It is nine acres in extent, and is the headquarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. Under such restrictions as are found necessary by the committees of the several clubs, and are approved by the council of the Clubs' Union, every member of the Union has opportunities of practising and taking part in matches, and in the various sports and games. There is a large pavilion upon the ground, with dressing and lavatory accommodation. Refreshments can be obtained by members of the Union according to the tariff of the Students' Club.

The ground-man, who is a professional cricketer, has quarters in the pavilion. His duties are to keep the ground in order, to prepare the wickets and lawn tennis courts, and to bowl to such members of the Union as shall be selected by the committee of the Cricket Club. Lockers may be rented on application to the groundman, at a charge of 5s. for the summer or winter season, 2s. 6d. deposit is also required on the key.

Cheap railway tickets between London Bridge and Honor Oak Park stations are issued to members of the Union upon conditions which will be found enumerated in the Clubs' Union Blue Book.

THE HOSPITAL "BLUE."—The "Blues" Committee, consisting of two representatives from each associated club, award "Blues" and "Half-Blues" to members of the following teams:—Rugby Football, Association Football, Cricket, Athletic, Lawn Tennis, Water Polo and Bicycle, after considering the list of men suggested by the various Clubs' Committees through their delegates. Blues are awarded half-yearly, at the end of each session, so that the Rugby Football team be represented by fifteen Blues, the Association Football by eleven Blues, Cricket by eleven Blues. The Athletic by Blues and Half-Blues, dependent on the recommendation of the Athletic Committee, according to the performances at the Inter-Hospital sports. The Lawn Tennis by three Blues and three Half-Blues, the Water Polo by seven Half-Blues, and the Bicycles by six Half-Blues.

CONSTITUENT INSTITUTIONS.

THE FOOTBALL CLUBS.—President, W. H. A. Jacobson, M.Ch. Rugby—Captain, H. A. Cutler; Hon. Sec., A. H. E. Wall; Captain Second XV., R. D. Bridger; Captain Third XV., H. D. Smart; and a committee of five, one representing each year. Association—Captain, W. M. Robson; Hon. Sec., H. P. Wiltshire; Captain Second XI., P. A. Peall; and a committee of five, one representing each year.

The Rugby Football Club has now been in existence for over fifty years, the season of 1900-01 being the fifty-seventh. Very little is known about its early history. It is, however, recorded that when the Rugby Union was formed in 1871, the G. H. F. C. was one of the original pioneers, and the only hospital club in the movement; it then had a reputation second to none. The club's position in the football world was acknowledged by the Union electing J. H. Ewart to serve on its first committee, which included such historic names as A. Rutter president), E. H. Ash (hon. secretary), F. J. Currey, F. Stokes, and A. G. Guillemard. Amongst the many brilliant players who at one time or another have appeared for Guy's may be mentioned the following International footballers:—A. W. Pearson, W. W. Pinching, A. H. Jackson, L. Stokes (captain 1877-8), A. S. Taylor, W. G. Mitchell, A. Allport, H. W. Dudgeon (England); H. M. Jordan (Wales); R. Evans (Scotland); and F. O. Stoker (Ireland)

In 1874 the Inter-Hospital Challenge Cup was instituted, which Guy's was fortunate enough to secure for the first time. Since its institution, St. Thomas's has held the Cup ten times; Guy's six times; St. George's three times; London and St. Bartholomew's twice each; and Middlesex and St. Mary's once each.

In 1891, Guy's, Middlesex and St. Thomas's were left in, *the ties not being played out.*

Most men will be aware that we succeeded in losing the Cup last year, after a match which could only be called unfortunate. From the present aspect of affairs there is no reason why we should not regain our lost prestige in this coming season, if only men will evince the same keenness which they showed the year before last. The plea of lack of time cannot possibly be entertained, for continuous and good training need cost little more than half-an-hour a day. The ground is always open, and footballs can always be obtained from Harris, the groundman. The Gymnasium, too, must not be forgotten as a useful adjunct to getting fit. We have four fixture lists arranged this season, and we propose to hold trial games at the beginning of the season, the first being fixed for October 3rd. The form shown at these games will be considered by the committee in choosing representatives in future matches, so it is particularly desirable that all freshmen should make a point of turning out.

For the benefit of freshmen in particular, we may state that lists will be put up in the smoking-room and

elsewhere, on which intending players should place their names as early as possible.

The officers of the Club will be at all times very glad to give any information in their power.

The following matches have been arranged for this season:—

FIRST FIFTEEN.

Oct.	3	Trial game	Home
	6	Kensington	Home
	13	Lennox	Away
	17	Cambridge	Away
	20	Catford Bridge	Away
	27	Rosslyn Park	Away
Nov.	3	Wickham Park	Home
	7	Royal Engineers	Away
	10		Away
	17	Bedford	Away
	24	Old Merchant Taylors	Home
Dec.	1	*Blackheath	Away
	8	Croydon	Home
	15	London Scottish	Away
Jan.	5	Old Leysians	Away
	12		Away
	19	Rosslyn Park	Home
	26	Harlequins	Home
Feb.	2	Catford Bridge	Home
	9	Kensington	Away
	16	Lennox	Home
	20	R.I.E.C.	Away
	23	Croydon	Away
Mar.	2	Marlborough Nomads	Away
	9	Richmond	Away
	16	London Irish	Home

*Combined with St. Thomas's Hospital.

SECOND FIFTEEN.

Oct.	6	Kensington	Away
	13	Lennox	Home
	20	Streatham	Away
	24	St. Thomas's Hospital	Away
	27	Redhill and Reigate	Away
Nov.	3	R.N.C. Old Boys	Away
	10	Beckenham	Home
	17	Old Alleynians	Home
	24	Royal School of Mines	Away
	28	Boro' Road New College	Away
Dec.	1	Old Merchant Taylors	Home
	8	Croydon	Away
	12	St. Bartholomew's Hospital	Away
	15	Streatham	Away
Jan.	5	Rosslyn Park	Home
	12	R.N.C. Old Boys	Home
	16	St. Thomas's Hospital	Home
	19	Hammersmith	Away
	23	St. Bartholomew's Hospital	Home
	26	Beckenham	Away
Feb.	2	Marlboro' Nomads	Away
	9	Kensington	Home
	13	Merchant Taylors School	Home
	16	Lennox	Away
	23	R.I.E.C.	Away
Mar.	2	Polytechnic	Away
	9	Marlboro' Nomads	Home
	16	London Irish	Away

THIRD FIFTEEN.

Oct.	6	Catford Bridge II.	Away
	13		
	20	Old Alleynians A	Away
	27	Kensington III.	Home
Nov.	3	St. Paul's School II.	Away
	10	Richmond St. Mary's	Away
	17	King's College Engineers II.	Away
	21	Tonbridge School II.	Away
	24		
Dec.	1	Dulwich College II.	Away
	8	Blackheath School	Away
	15	Catford Bridge II.	Home
Jan.	5		
	12		
	19	Polytechnic A	Away
	26	Dulwich College II	Away
Feb.	2	Richmond St. Mary's	Away
	6	Blackheath School	Away
	9	Polytechnic A	Away
	16		
	23	King's College Engineers II.	Home
Mar.	2		
	9		
	16		

FOURTH FIFTEEN.

Oct.	6		
	13		
	20	Court Hill A	Away
	27	Old Alleynians III.	Away
Nov.	3	Wasps III.	Away
	10	Catford Bridge III.	Away
	17	Streatham III.	Away
	24		
	28	Dulwich College III.	Away
Dec.	1	St. Paul's School III.	Away
	8		
	15		
Jan.	5		
	12	Court Hill A	Away
	19	Streatham III.	Away
	26	Blackheath B	Away
Feb.	2	Wasps III.	Away
	9	Dulwich College III.	Away
	16	Old Alleynians III.	Away
	23	Catford Bridge III.	Away

The Association Club has now been in existence for eighteen years, being instituted in 1882. Since that time it has, for the most part, been in a flourishing condition. For the first four years after the institution of the Inter-Hospital Challenge Cup (1886–89) Guy's obtained that trophy, and in two of these years, 1887 and 1889, won the Surrey County Cup as well. In 1894, the Inter-Hospital Cup was again won, and once more in 1897. Guy's have now held the Cup oftener than any

other hospital, having won it six times out of a possible fourteen.

Amongst the prominent players who have represented Guy's in Association football may be mentioned H. J. Holman, H. B. Bolus, E. T. Mitchell, H. Hickman, N. C. Cooper, N. Lavers, A. M. Daniel, A. B. Carter, R. T. Fitz-Hugh, H. M. Barker, L. Humphry, and J. McAlpin.

If freshmen come forward as they are expected to do, we should find no difficulty in making up the team again to former strength.

There are two trial games this season, October 3rd and 6th, so that all men should be able to play. Freshmen especially should turn out for these, otherwise their play may never be seen, and so their talent wasted. Lists will be posted in the colonnade and smoking-room for men to put down their names and the position they play in. We should urge on members of the team, who are unable to play in any match, the necessity of scratching their names off as soon as the list is put up, instead of waiting till the last moment.

The Cup must be brought back again this season if possible, and to do this the team must be settled as early in the season as possible and the same men play regularly. If this is done we have a good season before us.

The following matches have been arranged:—

FIRST ELEVEN.

Oct.	3	Trial game	
	6	Trial game	
	13	Old Harrovians...	Home
	20	Idlers	Home
	24	Hastings	Away
	27	Beckenham	Away
Nov.	3	...	
	10	Eastbourne	Away
	17	Reigate Priory	Away
	21	Nondescript (Cambridge)	Home
	24	Ramsgate	Away
Dec.	1	Ewell	Home
	8	Surbiton Hill	Home
	12	St. Leonards	Away
	15	Old Foresters	Home
Jan.	5	Old Eastbournians	Home
	12	West Kent Football Club	Home
	19	Beckenham	Home
	26	Weybridge	Away
Feb.	2	Ewell	Away
	9	Idlers	Away
	16	Reigate Priory	Away
	23	Tunbridge Wells	Away
Mar.	2	Surbiton Hill	Away
	9	Godalming	Away

SECOND ELEVEN.

Oct.	13	Central Technical College	Away
	20	Old Foresters	Away
	24	City of London School	Home
	27	Beckenham 2nd XI.	Home
Nov.	3	L.C.C.	Home
	10	Woodford Albion	Home
	17	St. Thomas's Hospital 2nd XI. ...	Home
	24	Banstead	Home
Dec.	1	Ewell 2nd XI.	Away
	8	Surbiton Hill 2nd XI....	Away
	15	Croydon Park 2nd XI...	Away
Jan.	12	Banstead	Away
	19	Beckenham 2nd XI.	Away
	23	City of London School	Away
	26	Central Technical College	Home
Feb.	2	Ewell 2nd XI.	Home
	9	Croydon Park 2nd XI...	Home
	16	Kenley (reserves)	Home
	23	St. Thomas's Hospital 2nd XI. ...	Away
Mar.	2	Surbiton Hill 2nd XI....	Home
	9	Kenley (reserves)	Away

THE CRICKET CLUB.—President: W. A. Brailey, Esq., M.D. Captain: F. C. Wetherell. Vice-Captain: G. S. Graham-Smith. Hon. Secretary: M. C. Wetherell. Captain second XI.: J. J. Hicks; and a committee of five.

Guy's generally turn out a good cricket team, and the most pleasing feature of the season this year was the remarkable success of the 2nd XI.

Since the institution of the Hospitals' Cup, Guy's has been the successful competitor on no fewer than eleven occasions, though at present the trophy is, like many others, absent from our smoking room, excess of work in these days of "keenness" being probably the predisposing cause of the dearth of athletic talent. In the Cup-ties of past years the following have secured three-figure innings, J. C. Shenton, W. J. Scott, F. Colclough, J. H. Joyce, W. I. Hancock, C. J. Francis and F. C. Wetherell.

In bowling, C. H. Rygate and J. D. Cruikshank took all the King's wickets in 1886 at the moderate cost of *three* runs; J. H. Bettington secured seven wickets for 21 against Bart's. in 1890, as did W. G. Mitchell against St. Mary's in 1887; J. H. Joyce in 1893, captured twelve of the King's wickets for 36, and eight of Westminster's for 19 runs; F. C. Wetherell took five University wickets for 15 runs in twenty-three overs in 1897. In the batting talent of the present generation there are one or two who bid fair to uphold the glories of the past.

In conclusion we should like to add that those who play cricket for Guy's will be able in after years to look back on many an enjoyable day spent among friends in the pursuit of a healthy pastime; and if in future years they win the Cup, let them know that a ray of sunshine is brought into the life of many an old Guy's man and that even members of the Staff will smile.

THE ATHLETIC CLUB.—President: R. Clement Lucas, Esq., B.S., F.R.C.S. Hon. Secretaries and Treasurers: D. H. Trail and R. S. Roper; and a committee of ten. The annual meeting of the Athletic Club is held in June at the Club's Union Ground, Honor Oak Park. From amongst the successful competitors, the team to do battle for Guy's at the United Hospitals meeting is selected. Since the institution, in 1867, of the Athletic

Championship of the United Hospitals—the first inter-hospital competition of any kind—Guy's, who were the first to secure the shield, have won it on eight occasions, St. Bartholomew's ten times, St. Thomas's five times, St. Mary's four times, King's and St. George's three times each, and London once. Among the prominent athletics who have performed for Guy's are:—W. Malby, who appeared for North v. South in the two miles during 1873; A. W. Pearson, J. Reader, J. G. Gravely (1877), hurdles, who held the record for some years; L. Stokes, A. S. Taylor, W. G. Mitchell, H. A. Munro, who for five years (1891–95) won the mile and three miles, in each of which he holds hospital record, and in 1895 he won the amateur championship for four miles; H. T. S. Bell, who has three times (1892–94) won the 100 yards, twice (1892–3) each the 220 yards and high jump and long jump (1893–4); in his last year he also tied for first place in the "high"; P. R. Lowe, hurdles (1892–93); F. S. Batchelor, 440 yards (1893); E. N. Scott, throwing the hammer (1893–94–95), and F. W. Sime, 100 yards (1898), and 220 yards (1898–99). A meeting—the date of which is October 8th—will be held at St. Bartholomew's Hospital of those interested in cross-country running, in order to discuss the future of the United Hospitals Cross Country Club. It is hoped that as many new men will be able to be present as possible.

THE LAWN TENNIS CLUB.—President: W. Arbuthnot Lane, M.S., F.R.C.S. Vice-President: J. W. Washbourn, M.D. Captain: H. K. Lacey. Hon. Secretary and Treasurer: E. N. Jupp; and a committee of eight. The club has been in existence some nine years. There are twelve very good grass courts at Honour Oak, which are open for play from the end of April to the end of September. The club holds, at the beginning of the season, several trial games, which serve to bring before the notice of the committee all promising new players, while one or two matches are played weekly against various London clubs. The Inter-Hospital Challenge Cup was instituted in Jubilee year: it was held by St. George's until 1890; Guy's held it in 1891–1892; St. Thomas's, 1893–1896: St. Bartholomew's, 1897; London, 1898; St. Bartholomew's, 1899; and this year it was won again by St. Bartholomew's.

THE RIFLE ASSOCIATION.—President: L. A. Dunn, M.S., F.R.C.S. Vice-President: G. Newton Pitt, M.D. Captain: B. W. Moss (Artists R.V.) Hon. Secretary and Treasurer: R. G. Oram (Artists R.V.); and a committee of five.

The Association arranges matches with the sister hospitals of London and with public school cadet corps, and also enters a team to compete for the United Hospitals Challenge Cup (held by Guy's in 1898) at Bisley during the "week." In the former series both Civilians and Volunteers are eligible to represent the hospital, but in the latter the regulations of the N.R.A. preclude any save Volunteers from competing. For this reason all new men who wish either to continue or to commence rifle shooting are requested to communicate immediately with the hon. sec. of the Association, who will give them information with regard to suitable volunteer corps.

The Annual Prize Meeting and Newton Pitt Challenge Cup Competition will be held early in October. The exact date will be posted on the notice-board in the Colonnade.

THE BICYCLE CLUB.—President: C. H. Golding-Bird, F.R.C.S. Captain: A. M. Gabriel. Vice-Captain: N. W. Green. Hon. Secretary and Treasurer: A. H. Forbes; and a committee of six.

The Club meets for runs every Saturday, except when engaged in race meetings, of which there are four every year, in addition to hospital contests.

A general meeting for the election of officers, etc., will take place in November, and all students who are cyclists are requested to communicate with the Hon. Secretary, or any member of the committee, and thus obtain full particulars.

The object of the club is to promote social runs among the members. In addition to several valuable prizes for competition, the President has given a very valuable cup to be raced for annually by members, the winner holding the championship for the season. The Captain is the present champion. It is hoped that all speed men will make themselves known, so as to be of service during the coming season.

The hospital has been represented in the United Hospitals, Cambridge, Oxford, London B.C., and Sheen House matches, and this year has won the Challenge Shield for the sixth time in succession.

GUY'S HOSPITAL SWIMMING CLUB.—WATER POLO.—President: L. A. Dunn, Esq., M.S. Vice-Presidents: A. D. Fripp, Esq., M.S., J. Fawcett, Esq., M.D., H. R. Wood, Esq., L.D.S. Captain: R. Franklin. Vice-Captain, D. Steele-Perkins. Hon. Sec. and Treasurer: C. H. Reinhold. Committee: A. E. Steele-Perkins, J. S. Saunders, R. E. Brayne, H. N. Grove, H. S. French.

The season of 1900 has not been a good one, in spite of the fact that we had an old Cambridge half-blue keeping goal for us. There has been a marked falling-off in keenness, and little practising and combined play; however, there are two or three excellent individual players, and with the talent which we are sure to find among the new-comers, we ought to muster a good team next year; but nothing can be done without practice and combination. A few years ago Guy's had the strongest water polo team in London, and used to beat the 'Varsities single-handed. We will be content next season if we beat the other hospitals, which is not impossible, if we have some budding Marshalls joining this year. We also want fast swimmers for the racing team, and hope men will come forward and not wait to be ferreted out.

Our thanks are due to Mr. Baker, the courteous superintendent of the baths.

THE PUPILS' PHYSICAL SOCIETY.—Hon. President: Sir Samuel Wilks, Bart., M.D., LL.D., F.R.S. Hon. Secretaries: G. Bellingham Smith, B.S., and A. P. Beddard, M.D.

This flourishing society was founded in 1830, on the plan of the old Physical Society, which existed during the latter part of the eighteenth century at Guy's Hospital. From a copy of the old laws of the Physical Society, dated 1800, we learn that the society met every Saturday night, from seven to ten, during the month of October, and each month until the following May. Business at these meetings was divided into private, including "matters in which the Society may be concerned," and public, consisting "in the communication of cases and opinions." A fine of sixpence was exacted from a member absent at the "Roll Calls," also from a member refusing "to hold up his hand on one side or the other," to decide any question. Members were divided into honorary, ordinary and corresponding. So much for the old Physical Society, of which an account is given in the *Biographical History of Guy's Hospital*, by Bettany and Wilks, a work which every Guy's man should possess. It may be obtained from the librarian, who has still some copies of the first edition, price 10s. 6d.

At the Pupils' Physical Society, which meets fortnightly on Saturday evenings, a paper on some subject, not necessarily of medical interest, may be read by any member to be followed by a discussion.

"Clinical and Pathological Evenings" are devoted to the exhibition and discussion of interesting cases or specimens which may be shown by any member.

On October 6th, 1900, there will be a general meeting of the Society. Sir Samuel Wilks, Bart., F.R.S., will be in the chair, and Mr. F. Curtis will read a paper, "Notes from an Ornithological Cruise in the North Polar Seas."

Members are reminded that in connection with the Society the following prizes are offered for competition:—The Treasurer's Prize of £5 is given annually, and the subject of the Essay for the ensuing session is "The Treatment of Uræmia." The Society offers a prize of £10 for the best paper read during the session; a prize of £5 to the member who distinguishes himself most in the discussions; and a prize of £5 to the member who exhibits the best specimens of scientific interest during the session (see Clubs' Union Blue Book, page 57).

THE DENTAL SOCIETY.—President: J. L. Payne, M.R.C.S., L.R.C.P., L.D.S. Vice-Presidents: A. E. Baker, M.R.C.S., L.R.C.P., L.D.S.; F. W. Cock, M.D., M.S.; E. B. Dowsett, L.R.C.P., M.R.C.S., L.D.S.; C. H. Fagge, M.S., F.R.C.S. Hon. Secretary and Treasurer: S. C. Bowle. Committee: E. J. Gaffney, C. A. W. Buckell, H. Winckworth, E. Lowe, L. Myer.

The Society was founded in the early part of 1894. Its sixth session commenced in October last, and was eminently successful in every way; good papers were read and much interest was taken in the meetings by the members.

Meetings are held every month during the winter session. They are held in the Dental Lecture-room on the second Friday in each month, at 4 p.m. Papers on subjects of dental interest are read, after which a discussion takes place; clinical cases are also shown at each meeting; and one evening during the session is specially set apart as a clinical evening. This year a prize of £5 will be given for the best paper read before the society. The first meeting will take place on October 12th, at 4 o'clock p.m.

THE GUY'S HOSPITAL CHRISTIAN UNION (Hon. Secretaries: C. S. Morris, G. H. Steweni and C. Tessier) has for its object the furtherance of the Christian life at Guy's Hospital. It is the perpetuation of the meetings instituted here by Drs. Habershon and Golding-Bird over forty years ago. On Thursdays, at 5 p.m., addresses are given by visitors invited for the occasion. These meetings are held in the board-room by the kind permission of the Treasurer. A room (No. 43) in the College is rented by the members for committee meetings, prayer meetings (daily at 1.10 p.m.), tea, and social intercourse. The Missionary Society, which is strictly undenominational, is doing good and useful work. The attempt thus made to unite the interest of the students in the work which is being carried on in foreign lands by medical missionaries, and to increase the knowledge of missionary work, has proved to many a source of helpfulness.

The opening meeting of the Union will take the form of a conversazione, to which all members and freshmen are invited, and will be held at 5 p.m., on Thursday, October 11th, in the board-room, on which occasion Dr. Pye-Smith hopes to preside. On October 18th the annual sermon will be preached in the chapel of the hospital at 4.30 p.m. On each preceding occasion there has been a large attendance, and it is hoped this year will see a large congregation.

The list of meetings for the ensuing quarter will be published shortly. Copies may then be obtained in room No. 43 in the college or from the secretaries.

THE DEBATING SOCIETY.—President: F. W. Pavy, M.D., LL.D., F.R.S. Vice-Presidents: J. Fawcett, M.D., W. C. C. Pakes and E. I. Spriggs. Hon. Secretaries: L. E. Stamm, E. H. Griffin; and a Committee of six students.

The Debating Society is entering on its ninth year of existence, and its seventh as a constituent of the Clubs' Union.

Five meetings are usually held in rotation with the Physical Society and the Smoking Concerts. Any subject except theology may be debated. Private business is allowed. A "Ladies' Night" is held at the end of the Session, at which members bring their freinds who are eligible to speak.

The secretaries, or any member of the committee, are always happy to receive suggestions or notices of motion. Except at "impromptu" debates no one is called upon to speak. The society has been exceedingly flourishing during the last two years.

THE GUY'S HOSPITAL GAZETTE is published on alternate Saturdays, from the library of the hospital, where copies may be obtained by all members of the Clubs' Union and by immediate subscribers.

Established in 1872, the GAZETTE was the first journal of its kind ever published in this country. It ran an uninterrupted course until November, 1879, and was then suppressed by the hospital authorities rather from excess of zeal than from lack of material. The present "new series" was inaugurated in 1887, and since that time it has continued to flourish without a break. The original GAZETTE was a two-leaf publication, and only had a small circulation in the hospital itself. Its circulation now practically includes all Guy's men throughout the world, as well as the Nursing Staff past and present.

The management of the GAZETTE is vested in a committee, constituted as follows. Three members of the Hospital or School Staff, *appointed yearly* by a School Meeting. Two students, appointed yearly by the Clubs Union Council. The President of the Residents for the time being. An Editor appointed by the Committee. A Manager appointed by the Committee, and other students not less than four in number and not more than six co-opted by the Committee.

The columns of the GAZETTE are open to contributions and correspondence from all sources, the writer's name being requisite as a guarantee of good faith, if not for publication. All contributions must be deposited in the editor's box in the colonnade, or addressed to the editor by post not later than Wednesday in each week of issue.

THE REPORTS.—Edited by W. H. A. Jacobson, M.Ch., and E. C. Perry, M.A., M.D.

The first volume of the Guy's Hospital Reports appeared in 1836. The Reports are published periodically, and contain contributions upon professional and scientific subjects from the staff of the Hospital and Medical School.

THE STUDENTS' CLUB.—Committee till 1900 (March). President: P. H. Pye-Smith, M.D., F.R.S. Treasurer: W. Hale White, M.D. Hon. Secretary: A. W. Ormond, F.R.C.S. Hon. Assistant Secretary: F. G. Cross, and a committee of eight.

The above-named manage the affairs of the Club, a full account of which will be found in the Clubs' Union Blue Book, p. 67.

GYMNASIUM.

The Pavy Gymnasium, which was built and furnished by the liberality of Dr. Pavy, is open daily for practice, and during the winter session a boxing instructor attends on each Thursday afternoon, and a gymnastic and fencing instructor on each Tuesday afternoon. At the end of the session a competition for prizes is held, and a display of gymnastics and boxing and fencing is given on the "Ladies' Night."

The course of boxing for the season 1900–1901 is in process of arrangement. The first class in fencing and gymnastics will meet on a date to be announced later.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

CASES UNDER DR. TAYLOR.

MARY	38.	Tuberculous pleurisy and peritonitis.
	40.	Pleurisy with effusion. Pgy. jaundice.
	41.	Transverse myelitis.
	42.	Gastric ulcer. Thrombosis of femoral veins.
	43.	Cerebral embolism. Mitral stenosis.
	44.	Enteric.
	46.	Enteric.
	47.	Phthisis.
	48.	Mitral regurgitation.
	49.	Acute rheumatism.
	50.	Thrombosis after pleurisy.
Cot	52.	Marasmus.
	57.	Empyema.
PHILIP	21.	Acute rheumatism. Pericarditis. Pleurisy. Mitral disease.
	22.	Acute rheumatism. Erythema multiforme.
	23.	Cerebral hæmorrhage. Aphasia.
	24.	Acute rheumatism. Mitral regurgitation
	25.	Enteric.
	27.	Aortic regurgitation. Abdominal aneurysm.
	28.	? Cerebral hæmorrhage.
	29.	Mitral stenosis and regurgitation.
	30.	Mitral regurgitation.
	33.	Lardaceous nephritis.
	34.	Old peritoneal adhesions. Right pleurisy.
	35.	? Acute bronchitis.
	36.	Appendicitis.
	37.	Aortic stenosis. Dilated and hypertrophied heart
	38.	Enteric.
	39.	Jaundice.

CASES UNDER DR. HALE WHITE.

MARY	13.	Grave's disease.
	14.	Acute osteo-arthritis.
	17.	Pyloric obstruction.
	18, 19, 22.	Mitral disease.

MARY 21. Mercury poisoning.
24. Cerebral tumour.
Cot 53. Posterior basic meningitis.
PHILIP 2. Carcinoma of liver.
4. Aneurysm of thoracic aorta.
6. Simple chronic peritonitis.
7. Abdominal aneurysm.
8. Appendicitis.
10. Chronic tubal nephritis.
14. Dilatation of stomach.
15. Disseminated choroiditis. Gumma of testis. Nephritis.
18. Gonorrhœal synovitis.

CASES UNDER DR. PERRY.

MARY 1. Chronic constipation.
2. Pericarditis. Mitral stenosis. Right pleurisy.
3. Chlorosis.
4. Hæmoptysis. Phthisis.
5. Enterica.
6. Hydronephrosis. Drained.
7. Rheumatism. Pericarditis.
8. Enterica.
9. Vomiting. Glaucoma.
10. ? Congenital heart lesion.
11. Subacute rheumatism. Mitral disease.
12. Alcoholic peripheral neuritis.
STEPHEN 2. ? Renal calculus.
3. Rheumatism.
4. ? Appendicitis
5. Tuberculous peritonitis.
6. Acute rheumatism. Mitral regurgitation.
7. Enterica.
8. Subdiaphragmatic abscess. Staphylococcal.
9. Sarcoma of tonsil.
11. Skin and joint lesions.
12. Sarcoma of right lung.
13. Enterica.
14. Enterica.
15. Double aortic and mitral disease. Acute rheumatism.
16. Appendicitis.
17. Asthma.
18. Rheumatism.
19. Peripheral neuritis. Gout.
20. Chorea.

CASES UNDER DR. BRYANT.

STEPHEN 22. Aortic stenosis and regurgitation. Mitral regurgitation.
23. Enteric.
24. Pneumonia.
25. ? Lardaceous disease.
27. Pericarditis.
28. Rheumatism. Endocardits.
31. Alcoholic peripheral neuritis. Phthisis.
32. Leucocythæmia.
STEPHEN 33. Enterica.
34. Carcinoma of stomach.
35. Carcinoma of pylorus.
36. Pleurisy. Pericarditis.
37. Leucocythæmia.
38. Cerebellar tumour.
40. Aortic stenosis and regurgitation. Mitral regurgitation.
MARY 25. Enterica.
26. Purpura.
27. Chlorosis.
28. Gastric ulcer.
29. Pneumonia.
30. Appendicular abscess.
31. Intrathoracic growth.
32. Enterica.
33. Enterica.
34. Right hemiplegia. Mitral stenosis.
35. Gastric ulcer.
36. Chronic mediastinitis.
37. Cirrhosis.
Cot. Pneumonia.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

ASTLEY-COOPER 3. Fractured patella.
5. Fracture dislocation of spine (since died).
5. Fractured astragalus.
11. Contused kidney.
JOB 4. Strangulated inguinal hernia. Spontaneous reduction.
6. Epithelioma of upper jaw. Excision of jaw.
9. Lupus vulgaris. Erosion.
21. Epithelioma of lower jaw.
23. Anthrax. Pustule on neck. Excised.
LYDIA 3. Varicose veins.
5. Wound of palate.
6. Epithelioma of tongue.

CASES UNDER MR. LUCAS.

LAZARUS 1. Double inguinal hernia and left varicocele.
5. Recurrent epithelioma of cervical glands
9. Psoas abscess. Kyphosis.
16. Varicocele. Excised.
MARTHA. 6. Painful cicatrix.
23. ? Tuberculous kidney.
24. Scirrhus of breast.

CASES UNDER MR. GOLDING-BIRD.

CORNELIUS 7. Separated lower humeral epiphysis.
LUKE 3. Inguinal hernia. Radical operation.
12. Varicocele. Excised.
15. Epithelioma of cervical glands.
17. Tubercular cervical adenitis.
20. Fibroid omental ventral hernia.

Charity	1.	Hæmatemesis. Gastric ulcer.
	19.	Appendicitis.
	Cot A.	Nævus of mouth.

Cases under Mr. Jacobson.

Astley-Cooper	2.	Crush-fracture of foot.
	22.	Fractured femur.
Cornelius	14.	Fractured tibia and fibula.
Naaman	1.	Double inguinal hernia and varicocele.
	3	Epithelioma of tongue.
	8.	Sublingual exostosis. Excised.
	13.	Loose body in knee-joint.
Dorcas	3.	Lipoma of buttock. Excised.
	9.	Nævoid condition of feet.
	10.	Genu valgum.
	21.	Hæmaturia. ? Calculus. ? Tubercle of kidney.

Cases under Mr. Symonds.

Job	18.	Œsophageal stricture. Intubation.
Lydia	20.	Puerperal arthritis.
	21.	Cystic bronchocele. Excised.
Samaritan	11.	Septic osteo-myelitis of carpus.

Cases under Mr. Lane.

Lazarus	14.	Intra-cranial tumour. ? Gumma.
Martha	2.	Dilatation of carotid bifurcation. Exploration.
	3.	Chronic mastitis.
Samaritan	12.	Necrosis of phalanx. Erosion.

Cases under Mr. Dunn.

Luke	4.	Inguinal hernia. Radical operation.
Charity	22.	Contracted extensor tendons of feet.
	Cot D.	Rickets.

Cases under Mr. Fripp.

Naaman	20.	? Renal calculus.
	22.	Varicose veins.
Dorcas	21.	? Renal calculus.
Patience	—.	Cellulitis of hand. Incised.

Some Notes on the Imperial Yeomanry Hospital.

Imperial Yeomanry Hospital,
Deelfontein,
August 6th, 1900.

This is really little more now than a large convalescent camp. It is extraordinary what a tremendous change has come over the place since a fortnight ago when we were still very busy. We have had no death for two whole weeks, and we have not taken in an ambulance train-load for three weeks. Very nearly a hundred Yeomen have been admitted during the week, but they are almost without exception convalescents from other hospitals. For instance, all the wounded, consisting of Warwicks, Gloucesters and Lancashires, from the action nine weeks ago at Kheis, have come on here from the Orange River hospital. Just over six hundred officers and men of the Yeomanry have been passed through the hospital since it was opened. Of course a very large number of Yeomanry have been laid up in other hospitals, it having been found impossible from one cause and another to have them sent here. Thus, many in the acute stages of illness it would not be safe to move: others are laid up in parts of the Free State almost inaccessible to proper hospital transport, but the facilities of collecting in this hospital all those Yeomen who are in a fit condition to travel have been progressively increased daily, and the arrangements to that end are now, I believe, as nearly perfect as the complicated conditions of the case permit. There is, for instance, a standing order at De Aar (which is the next station north of us, and through which all patients going down country must pass) ensuring that every train is warned to stop at Deelfontein and discharge any Yeomanry it may contain. Also directly we hear there are any Yeomanry in a hospital up-country, we telegraph to the Commandant of that hospital and ask him to send them to us as soon as they are fit to travel. But if we are right in supposing that the number of Yeomanry in South Africa is about ten thousand, we have already had through our hands not less than six per cent. of them, a heavy proportion when you consider that none of that limb of the Service have been out here for more than five months.

Out of this six hundred already treated here, there have only been four deaths, while out of the total number of admissions to the hospital of two thousand five hundred and fifteen, there have been in all fifty-nine deaths, a mortality of two and a half per cent., which is attributable almost entirely to enteric.

Since last week, when I think I mentioned that we had run out of tobacco, a very large quantity has arrived. Much of this has been contributed as presents by kind people at home; and, lest I forget, I want to take this opportunity of thanking all my wife's and my own personal friends who have shown us so much kindness in writing to us and in sending out so many gifts for the use of the patients. One most acceptable present was made by a lady, who sent five hundred and forty-eight eggs from England. Thirty-four pounds of sweets from Buzzard's, many pounds of chocolate, dozens of cases of food preparations, and many contributions of tobacco and pipes, equally generous in their intention whether in quantity they have been large or small, we also owe our thanks for. I only wish the donors could see the immense amount of pleasure their thoughtfulness has given to the patients, and also that they could appreciate the encouragement it gives to the staff to have these perpetual reminders of the kind thoughts of friends at home. Everybody one comes across out here is struck with the great liberality and thoughtfulness displayed throughout the war towards those who were fortunate enough to be able to come out by those who, from one

cause or another, were prevented from accompanying them. This liberality has been a revelation to everyone who has been in a position to realize the enormous amounts of useful presents which have been sent to South Africa. My impression, derived from pretty extensive acquaintance with the hospitals from Cape Town to Kroonstad and Mafeking, is that every hospital to which it has been possible to get the gifts transmitted has, owing to the work of the Red Cross Society and of allied institutions, and owing to the generosity of the numberless private individuals who have contributed in some form or another, found itself supplied with at least twice as much of such comforts and luxuries as tobacco, scent, scented soap, toilet vinegar, periodicals, books, warm underclothing and knitted articles, as it could at a pinch have done fairly well with.

It really seems as if the fighting had nearly come to an end at last, but we are still anxiously waiting for the news of De Wet's final downfall. The general impression out here is that it is only a point of honour which keeps Botha, who presumably is to be considered the Commander-in-Chief, from throwing up the sponge so long as one of his subordinates is in the field, but everywhere in South Africa we are behind you in England in regard to news. Except when a Staff Officer comes down to us from some part of the front, and tells us the latest "in private," we have to wait for reliable information till the two-days old Cape Town papers reach us, and even then the information has frequently been re-cabled out from London.

The weather is once again perfectly magnificent, and the health of the staff in general has very much improved since the work became lighter. I was very glad indeed to see that Dr. Conan Doyle had been calling attention, in the London Press, to the arduous and dangerous nature of the work done—and done cheerfully—throughout this war by the hospital orderlies. Among all the brave deeds and hard work done by the various branches of the army during the last ten months, I don't believe that any body of men in Her Majesty's Service has excelled, even if it has equalled in bravery and pluck and continuous, even monotonous laboriousness, the behaviour of thousands of men who have been employed in the hospitals They have been called upon to do, in addition to a full day's work every day, a full night's work every fourth or third, or even at times of stress, every second night. Their work has gone on month after month quietly and unostentatiously without any of the glamour attaching to deeds which catch the public eye. Many of them have died at their work, but very few indeed have grumbled. The service they have rendered to their country has indeed, in the fullest sense of the word, been splendid.

Several people have been asking what is to become of this hospital when the war is over. We have not yet heard that any decision has been arrived at, but as I told you many weeks ago my own hope is that it will be taken over as a going concern by the military authorities for the permanent use of the army of occupation, or, failing that, by the civil authorities, in which case it might be worked as a sanatorium with great advantage to the Colony, if not even to the Empire. It is a most perfect site for a large hospital, and its establishment is of such a substantial nature that without any but current expenses it could continue its useful work for many years. Every single thing that could be wanted (except of course consumable stores) even to the bacteriological laboratory, which is essential nowadays to any such large institution, is to be found here in full working order.

We have had several visitors since I wrote last. The Police Magistrate of the District came with his mounted police for the purpose of raiding our native encampment. We had reason to believe that some natives were lodging there without employment in the hospital, which alone gives them the right to remain near our camp. By surrounding the kraal with troops before daylight, and so preventing the escape of anyone, fourteen intruders were found. Having arrested them, Mr. Boyes proceeded to make a more systematic examination of the contents of each hut than we have ever been able to do, and the result was the recovery for the use of the hospital of a considerable quantity of blankets, china, buckets, and such like articles, and also the discovery of a lot of strong Kaffir beer, the presence of which near our camp had been known for some time on account of the number of white men in our hospital who had succeeded in getting intoxicating liquors.

On the same day that Mr. Boyes was here, Major Reade, R.A.M.C., and Major MacMunn, of the Volunteer Medical Staff Corps, who have been detailed by Lord Roberts to go over and prepare the ground for the investigations of the Medical Enquiry Commission, the members of which will arrive in South Africa on the 21st instant, and also Colonel Lucas, D.A.G. of the Yeomanry, and Colonel Deane, who have both just come out from England to make a tour for the purpose of collecting information bearing on the services rendered by the Yeomanry throughout the war, arrived as well. Surgeon Major Kilkelly, Grenadier Guards, who, as I told you in my last letter, has been most fortunately secured to act as Commandant of our branch hospital in Pretoria, was stopping here at the time on his way up from Cape Town, and with these six visitors I spent the whole day, making a complete tour of inspection of the hospital. They went very minutely into details and statistics and seemed very pleased with everything they saw, particularly with the sanitary arrangements, and with the laundry and disinfector and destructor. Indeed one trembles to think how fearfully the work of the hospital would have been hampered if the Committee in London had not foreseen the need for the heavy and extensive plant with which I am thankful to say we are equipped. Major Kilkelly was so struck with the excellence of the arrangements displayed by Miss Brereton in the various departments under her charge, that he asked for the loan of her services for the development of the new branch, so she and her friend Miss Leggett,

who has been working under her, are going up temporarily to Pretoria, and with their experience of the essentials of a mixed civilian and military hospital, coupled with that of Dr. Barclay Black and our Serjeant Major Mackay, who went up to Pretoria with Sloggett and are remaining there, and with that of Kilkelly, who, as you know, has been acting since last autumn as Commandant of the now disbanded Portland Hospital, the success of the new branch ought to be assured. There seems to be no doubt now that Pretoria will be its home.

I am glad to say Sloggett got back this morning. He was hung up for some days by a fresh cutting of the line south of Kroonstad this time. Everybody is glad to have him back, but nobody is more glad than I am, for the military administrative work is very uncongenial to a civilian who is not trained to it, and there is so much of it that on the top of one's multifarious other duties, it gives one the uncomfortable feeling that one is trying to do too many things, and in consequence doing much of one's work badly.

To-day is the August Bank holiday, so we had an open-air concert in the afternoon at which there was a large and enthusiastic audience. Two or three of the farmers in the neighbourhood brought their families in and seemed to enjoy themselves very much. Whether it is intentional or not we are not sure, but it is not a rare thing for certain of these guests to get up and walk away before "God Save the Queen" is played. Others, however, seem markedly loyal. But loyal or disloyal they lose no opportunity of varying their monotonous lives by taking part in any entertainments that are going on in our camp. I don't think that I ever told you that we are indebted to the ladies of the surrounding farms for having subscribed a fund for the purpose of putting a wall round our cemetery, whilst another Colonial well-wisher has contributed young trees which are being planted among the graves.

There was quite a good Association football match here on Saturday between teams representing our orderlies and those of the Pretoria branch.

A. D. FRIPP.

A Busy Day.

It is early morning at Waterfall Drift. The Ninth Division has marched north after crossing the Riet four hours ago; a few Highlanders and Mounted Infantry remain to help and guard the long train of ox and mule waggons carrying supplies for the Army. It is a busy scene; the river runs slow and turbid between steep banks of soft sand into which the waggon-wheels sink deeply; as they reach the bank an additional span of oxen is used, and the thirty-two beasts slowly drag up the labouring waggons to the accompaniment of hoarse cries from the native drivers and many slashes of their terrible whips, twelve foot of bamboo and eighteen of untanned hide, with which they can take a piece of skin out of an ox thirty feet away. These black drivers manage a span of oxen in a way no white man could ever hope to do; they will sort out their own sixteen from among hundreds grazing on the veldt, calling each by name with volumes of encouragement or abuse, and then they will walk by them the whole night through, rain or fine, keeping them up to their work with voice and whip. We are riding backwards and forwards getting the waggons into their proper places for crossing, helping those that are stuck and marshalling them upon the Eastern bank. But another factor is soon to be introduced into the scene of our labours; Christian de Wet with a thousand men and four guns is marching upon us from Koffyfontein, and suddenly we hear the hoarse shriek of a shell and its deafening report: over goes a waggon in the river with half its oxen killed, then hell seems to break loose among us; shell follows shell, and the cries of the men and bellowing of wounded and frightened oxen add to the confusion, while the air throbs with the irritating crack of the Pom Pom whose hail of shells sweeps backwards and forwards with frightful regularity. Along the struggling line the escort is riding to and fro threatening the blacks, who show a great desire to bolt, working like demons in the midst of the carnage trying to get the waggons on; but as soon as a waggon moves, it is seen by the watchful gunners on the heights and next minute half the oxen are dead. Being without guns we have no chance of reply as the enemy is quite out of range of rifle fire. After what seemed hours we received the order to leave the convoy and in the worst of tempers we ride north to Wegdraai, being however somewhat cheered by meeting some of the 14th Brigade hastening to try and rescue the convoy, but unfortunately it had to be abandoned the same night, and its loss caused later much inconvenience. Nine miles from Waterfall we reached Wedgraai, and had a short halt for food and joined our main body. We were then ordered to occupy Jacobsdal, five miles off, which we heard had been deserted by the Boers. Our line of scouts had approached to within eight hundred yards of this little village when a heavy fire was opened on them; there was very little cover and it was impossible to turn the Boers' right flank which rested on the Riet River. In a few minutes the Seventy-fifth Field Battery had galloped up. "*Action front!*" and their shells were exploding in the town, while some of the Mounted Infantry were already turning the left flank of the enemy, and the rest with the 2nd North Staffordshires rushed the village, which was quickly occupied by General Wavell and the 15th Brigade. We had just commenced to search for stores and water when the order came, "A company of Mounted Infantry will act as escort to a field telegraph section to open up communications with Lord Methuen," who was with the First Division at Modder River Station, twelve miles on our left. A few minutes' rest and there rattled into the market square a mule cart with a large reel of wire and many telegraph instruments, half a dozen men, sergeant and officer, bearing on their helmets the yellow patch of

the Royal Engineers. "*Subsections left! Walk march! Trot!*" and away we went down the drift and over the shallow Reit under the shadow of the blown up road bridge, and as the cart struggles after, the first section is already far away spreading fanwise over the plain. Away on our left there is an abandoned farmhouse, which is rapidly investigated, and the men come away festooned with chickens. The cart is across and struggling up the steep bank, leaving a long tail of wire behind, through which messages are constantly sent for test purposes. We are making good progress at a brisk trot and are getting level with some houses on the north bank of the river, when crack, crack, bullets are whistling overhead. We look round, already the cart is bumping off the track to shelter behind a slight rise, the scouts on our right have vanished into the river bed. The only shelter on the other side of the river is in the houses, so we know the enemy must be there. "*No. 3 Section line river bank and keep down the enemy's fire!*" "*No. 4 return and cross at a drift half a mile back and dislodge the enemy!*" We cannot leave them there or they would soon cross and cut our wire. Soon our men have dropped out of sight behind the river banks and have opened a steady fire on the windows and doors of the houses, preventing the Boers doing any damage to the telegraph cart, which has quickly started again. The enemy soon see the section who have crossed the river, and, as the odds seem against them, mount quickly and away, but the avenging bullets are quicker; over goes a horse bringing his rider down heavily, while another man sways in his saddle and in a few yards more rolls slowly off, while his well-trained pony stops and watches his lifeless master. The pony is caught and serves as a mount to the other Boer, who has now been taken prisoner. The two sections are quickly formed up and gallop after the cart and rest of escort which is caught up where it has halted a few miles on by the side of the stream. Horses and mules are led down the steep bank to water: one mule with the natural perversity of its kind falls into a soft place and has to be hauled out with ropes. We are soon off again and in a few miles more we can see countless tents upon the plain, with railway running north through them and disappearing on the horizon among the heights of Magersfontein, a place which wakens in us gloomy memories of Gen. Wauchope and the decimated Highland Brigade. We are soon among the tents left empty to deceive the enemy, over the drift on the Modder by the pontoon which has been built to replace the wrecked railway bridge, and in a few minutes more we have crossed the line and are reporting to "our Paul," as the men call Lord Methuen (along with another name which cannot be called complimentary). Little did we think that in another fortnight we should be standing on the same spot, having as prisoners the notorious Cronje and his vanquished army. After a welcome invitation to dinner we are off to the Mounted Infantry camp, but are delayed for over half an hour by a terrible sandstorm which prevents us seeing even our horses' ears. We are now passing over the famous battlefield, the scene of—to use Lord Methuen's words—"one of the hardest battles ever fought by the British Army." And here we lie down and rest by the railway leading south and home and as we look north we see patches of light upon the clouds, while from a truck close by, our answering search-light whirred and flashed, sending glad tidings to beleaguered Kimberley over miles of veldt and kopje, over Cronje's army hastening east, soon to be overtaken by their nemesis upon the dawn of Amajuba day.

The "Eastbourne" Improved Invalid Chair.

[PATENTED]

This chair, which is made from the design of an old Guy's man, is constructed with a view to the easy and ready conveyance of invalids from room to room or up and down stairs, and is peculiarly suitable to patients subject to nervousness or to whom shaking or jolting may be injurious. It moreover obviates much of the fatigue which is inseparable from the ordinary carrying chair.

By its use a patient of ordinary weight can be taken from room to room by one person only, or up or down stairs by two persons without strain or fatigue, and when it is explained that this can be done and is done daily by two nurses or domestics, its advantage over any other chair will be readily appreciated. Even patients of extraordinary weight can be conveyed up or down stairs by three domestic servants without any risk or strain.

It is claimed that the chair has the following advantages:—

1. It does away with any feeling of insecurity which patients feel by the use of the ordinary carrying chair, the weight of the patient and the chair itself resting at no time on the attendants.
2. There is no oscillation whatever.
3. All strain on the attendants is done away with.
4. The chair can be easily used by two maid-servants, and the necessity for employing men-servants or male attendants is obviated.
5. It is quite noiseless in action.
6. In addition to its use as a means of conveyance the chair can be used as an ordinary armchair for the patient, or by the patient when seated at table, so that all occasion for the patient being lifted from chair to chair is done away with.
7. The chair is very light and can be immediately moved from one part of a room to another at will.
8. The chair occupies very little space, and there are no long handles to get in the way.

The method of using the chair for conveying a patient up or down stairs is best shown in the accompanying illustration.

The following directions should be followed:—

1. For conveyance on the level.

   The attendant takes the handles at the back of the chair in which the patient is seated, and by pulling the same slightly towards him or her raises the footboard off the ground, the weight of the patient and the chair being thus transferred on to the wheels at the back. It can then be run easily from room to room or anywhere on level ground.

2. For conveyance downstairs.

   One of the attendants takes the chair by the handles as described for conveyance on level ground and runs the chair to the top of the stairs. On reaching the top step the other attendant, preferably from a level of about two steps below, takes hold of the footboard, and the attendant having control of the chair at the back, and retaining his or her hold of the handles, the wheels of the chair are allowed to run over the edge of the step when they rest securely on the tread of the stair immediately below, any jerking or jolting being controlled by the attendants. This process is repeated to the next stair, and so on until the foot of the stairs is reached.

   A little practice will make the process easy and simple.

3. To convey a patient upstairs.

   The method of conveying a patient upstairs is the exact reverse of conveying a patient downstairs. The attendant having control of the handles at the back of the chair proceeds backwards step by step, and when commencing stands preferably on the second stair from the bottom. The attendants by this method roll the chair on the wheels from step to step until the top is reached.

   It is recommended that the chair should be taken first once or twice up and down stairs by the attendants without the patient, when they will be easily able to follow these instructions.

The chair is not suitable for use on spiral stairs, where the width of the treads varies and is very narrow, but if required for use on such stairs the attendants must lift the chair over such portion and then proceed as indicated above.

The wheels of the chair rest safely on each tread, and if a hold of the handles is retained by the attendant at the back there is no fear of the chair running down the stairs.

In using the chair it is preferable that the attendant holding the handles at the back should, while ascending or descending stairs, keep the arms straight and at full length, pulling or lifting by the muscles of the back.

Appointments.

HOUSE APPOINTMENTS.

The following appointments have been made by the House Committee upon the recommendation of the Medical Committee:—

House Physicians.—Messrs. J. T. Dunston (Dr. Hale White); D. P. Watson (Dr. Perry).

Assistant House Physicians.—Messrs. F. Shufflebotham and A. H. Davies.

House Surgeons.—Messrs. R. C. Mullins (Mr. Howse); E. Cohen (Mr. Golding-Bird).

Assistant House Surgeons.—Messrs. T. P. Thomas, W. B. Secretan (Front Surgery); J. M. Brydone (Mr. Symonds); E. F. Reeve (Mr. Lane); T. E. Holmes (Mr. Dunn).

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants.—Messrs. J. A. B. Hammond, P. W. L. Camps, F. W. Sime, M. D. Wood, L. E. Stamm, K. V. Trubshaw.

Obstetric Dressers.—Messrs. J. D. Bridger, E. I. Claxton.

Dressers in the Throat Department.—Messrs. J. A. Butler, H. McD. Parrott, J. F. Robinson, J. S. S. Perkins, H. Wacher, T. J. Wright.

Assistant Surgeons' Dressers.—Messrs. W. W. C. Jones, W. C. Lewis, A. J. Urquhart (Mr. Symonds); C. E. Bartlett, R. H. Terry, F. M. V. Smith (Mr. Lane); A. E. H. Pakes, G. E. Malcomson, P. N. B. Odgers, F. H. Parker (Mr. Dunn); F. L. Thomas, A. J. Beadel, N. N. A. Houghton (Mr. Fripp).

Medical Ward Clerks.—Messrs. G. T. Wrench, A. W. Iredell, F. J. Turner, E. Faulks, H. T. Palmer, J. D. Pearson, T. M. Smith, M. C. Wetherell, C. J. Pinching, O. B. Travers, C. H. Dawe, K. Anderson, H. R. Grellet, C. H. Robertson, G. S. Robertson, W. E. J. Tuohy, J. B. Copland, C. M. L. Cowper, C. H. Denyer, J. T. Hicks, S. L. Pallant, A. P. Piggot, H. L. Shelton, G. W. Smith, E. W. Strange, H. Tipping, W. L. M. Day, B. Glendinning, E. H. Griffin, L. H. Moiser, C. M. Murray.

Assistant Physicians' Clerks.—Messrs. S. L. Prall (Dr. Shaw); W. H. Cole (Dr. Washbourn); L. Gifford Nash (Dr. Bryant).

Surgical Ward Clerks.—Messrs. J. Braithwaite, F. W. Fawssett, P. W. Hamond, F. C. Robinson, W. F. Box, R. E. Brayne, H. S. Brown, W. H. Bush, E. G. Goldie, H. M. Goldstein, H. S. Jones, E. N. Jupp, W. W. Read, B. H. Wedd, P. C. V. Bent, G. L. Buckeridge, C. F. Fraser, E. J. Gaffney, L. S. H. Glanville, J. M. Bickerton, J. H. Donnell, R. Larkin, B. B. Westlake, C. M. Anthony.

Clerks in the Skin Department.—Messrs. H. K. Lacey, D. L. Morgan.

Dental Surgeons' Dressers.—Messrs. C. B. Thomson (October–November); H. V. Bagshawe (November–December); D. R. T. Griffiths (December–January).

Assistant Surgeons' Clerks.—Messrs. E. H. B. Milsom (Mr. Symonds); C. D. Pye-Smith, P. R. Bolus (Mr. Dunn).

Post-mortem Clerks.—Messrs. E. J. F. Hardenberg, R. Jimenez, F. W. Smith (November–December).

Assistant Demonstrators of Microscopical Pathology.—Messrs. H. S. French, A. E. H. Pakes, A. C. H. Gray, C. Tessier.

DENTAL APPOINTMENTS.

The following appointments have been made by the House Committee upon the recommendation of the Dental Council:—

Assistant Dental House Surgeons.—Messrs. G. W. Badcock, A. H. Clogg (October–December).

Demonstrators in the Conservation Room.—Messrs. R. J. Green, H. C. Vesick, J. W. Walton (October–March).

Papers by Guy's Men.

Cephalotripsy for the after-coming Head. By J. H. Targett, M.S., F.R.C.S.—*British Medical Journal*, 15th September.

Birth.

SUTTON.—On August 17th, at Maison Range, Sidcup, the wife of C. R. Arnold Sutton, M.D. Camb., of a son.

Marriages.

GODSON—MAYALL.—On September 12th, at St. Thomas's Church, Werneth, Oldham, Alfred Henry Godson, B.A., M.B., B.C. Camb., F.R.C.S. Eng., eldest son of Alfred Godson, of Cheadle House, Cheadle Cheshire, to Mary Elizabeth, youngest daughter of the late Samuel Mayall, J.P., of Springside, Lees.

HINTON—LINGEN-BURTON.—On September 11th, at St. Eata's, Atcham, Shropshire, by the Rev. A. G. Burton, Vicar of the Parish, Hammond Tooke Hinton, M.B., C.M., youngest son of Joseph Hinton, M.R.C.S., L.S.A., of Heytesbury, Wilts, to Constance, third daughter of the late Robert C. Lingen-Burton, Shrawardine Castle, Shropshire, and of Mrs. R. E. L. Burton, of Selwyn House, Shrewsbury.

SPON—ROBINSON.—On September 5th, at St. Peter's Church, Drayton, Abingdon, Berks., Harry James Spon, M.R.C.S., L.R.C.P., D.P.H. Cantab., son of Francis Nicholas Spon, of Brockley, to Constance Mary, third daughter of the Rev. F. E. Robinson, M.A., Vicar of the Parish.

ED.—S. H.

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Calendar of Coming Events.

October, 1900.

Sat. 13.—Messrs. Jacobson and Fripp's take-in; Drs., M. J. Rees and A. Wylie; Cl., J. A. B. Hammond.
1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., I., Lennox, away.
II., Lennox, home.
G.H.A.F.C., I., Old Harrovians, home.
II., Central Tech. College, away.

Sun. 14.—Harvest Festival. Services 7, 8.45, 11 a.m., and 7 p.m.

Mon. 15.—1.15 p.m., Clinical lecture by Mr. Lucas.

Wed. 17.—1.30 p.m., Clinical lecture by Dr. Horrocks.
G.H.R.F.C., I., Cambridge, away.

Thur. 18.—Messrs. Howse and Symonds' take-in; Drs., F. A. Beattie and G. H. H. Manfield; Cl., L. E. Stamm.
G.H.C.U.—Annual Sermon, 4.30 p.m.

Sat. 20.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., I., Catford Bridge, away.
II., Lennox, home.
III., Old Alleynians "A," away.
IV., Court Hill "A," away.
G.H.A.F.C. I., Idlers, home.
II., Old Foresters, away.
G.H.P.P.S.. Clinical Evening.

Mon. 22.—1.15 p.m., Clinical lecture by Mr. Lucas.

Wed. 24.—1.30 p.m., Clinical lecture by Mr. Higgens.
G.H.R.F.C. II., St. Thomas', away.
G.H.A.F.C. I., Hastings, away.
II., City of London School, home.

Thur. 25.—Messrs. Lucas and Lane's take-in; Drs., W. M. Robson and M. A. Collins; Cl., P. W. L. Camps.
G.H.C.U., Address by A. B. Tessier, Esq.

Sat. 27.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C. I., Rosslyn Park, away.
II., Redhill and Reigate, away.
III., Kensington III., home.
IV., Old Alleynians III., away.
G.H.A.F.C. I., Beckenham, away.
II., Beckenham 2nd XI., home.

Guy's Hospital Gazette,

OCTOBER 13, 1900.

Purpura.

CLINICAL LECTURE BY Dr. HALE WHITE.

June 6th, 1900.

Gentlemen,—I intended to-day to finish what I began to tell you last time about the treatment of disease of the heart, but we have had in Clinical during the last few hours a striking fatal case of Purpura, and as the specimens would not keep till next week I thought we ought to take them now.

The history of the man is this. He was 64 years old, and was admitted into John ward on Monday last. He gave nothing in the previous history that bore upon the case at all. On Thursday of last week he felt ill, and on Friday he found that his tongue had some hæmorrhage into it and was therefore swollen; on Saturday the tongue was worse, and the mouth began to bleed from the gums, the general mucous membrane, and the lips. Next he noticed that his skin was covered with a number of hæmorrhages, and so on Monday he came up to the hospital and was admitted, and he had then all over his body a large number of hæmorrhages. There (produced) is a typical piece of skin from the patient, and you can see that he had very extensive purpura because you can see many hæmorrhagic spots under the skin.

On examining him further, we found that those hæmorrhagic spots were present all over his body, and, moreover, that the tongue had a large number of hæmorrhages in it. Here is the tongue (produced) and you can see how black it is from the large amount of hæmorrhage in it, and that one huge hæmorrhage has caused considerable swelling of the tongue.

Then, on examining further, we found that the mucous membrane of the mouth, especially in the neighbourhood of the gums, was bleeding profusely, and indeed in some places we were unable to see the teeth properly because of the large number of clots on the gums. After death I cut off for you a piece of mucous membrane from the lip, and you can see still adherent to it a large clot of blood.

The man's temperature was 99°. The blood in the mouth was already beginning to decompose, so that the breath was extremely foul. We

looked at the back of his throat, and we could see no mark of blood there. We could not, on admission, have a specimen of the urine, as the bladder happened to be empty. The lungs seemed healthy, the heart seemed healthy, there was no bleeding into the retina. During the night he died quite suddenly, and as he died suddenly we were able to forecast that he had probably died from cerebral hæmorrhage. The same sort of thing that you see in the skin had probably occurred in his brain. An estimate of the blood showed that the hæmoglobin and red corpuscles were reduced to the same extent, namely, about 40 per cent. No abnormal red or white cells were seen.

Well, now, I think the best way to consider that case will be to go over with you the causes of purpura. When we saw the patient the main thing was the excessive purpura.

Dr. Stephen Mackenzie has tabulated the causes of purpura in 200 consecutive cases admitted into the London Hospital, and I do not suppose that the experience there differs much from ours, and so we will take it as representing our own.

I have slightly modified the list and have written it up on the board.

TABLE OF THE CAUSE OF 200 CASES OF PURPURA.

Rheumatism	61
Doubtful rheumatism	10
Bright's disease	9
Heart disease	8
Anæmia	6
Scurvy	6
Privation	5
Tuberculosis	4
Drugs	3
Pyæmia	2
Malignant endocarditis	2
Congenital syphilis	2
Alcoholism	2
Injuries	2
Convalescence	2
Malaria	1
Rickets	1
Whooping Cough	1
Cirrhosis	1
Hæmophilia	1
Varicose veins	1
Peripheral neuritis	1
Henoch's purpura	0
Multiple sarcomata	0
Specific fevers	0
Unexplained	68
	200

On comparing these 200 cases you see that 61 were due to rheumatism. So the first thing we have to consider is, Was our patient suffering from rheumatic purpura? I must tell you, therefore, a few things about rheumatic purpura. Purpura rheumatica is also called peliosis rheumatica, and the name was first used by a German physician, Schölein, who described it seventy years ago. It is most unfortunate that this word peliosis rheumatica has got applied to the condition of purpura rheumatica. Schölein never described purpura rheumatica at all; what he *did* describe was erythema papulatum. But still by now the term peliosis rheumatica has got, by common usage, transferred from erythema papulatum to purpura rheumatica.

A patient who is suffering from purpura rheumatica is always a patient who either has had rheumatic fever, has got it, or will if he live long enough have it. Usually purpura rheumatica occurs in people of from ten to forty years of age; it is rare before ten and rare after forty. The patient usually gives you some tale of this sort. He says that on a given day, towards the evening of the day, he felt considerable pain in his lower extremities. He not unfrequently describes the pain as though there were some swelling, a sort of bursting pain, and then, he says, he looked at his legs and found that he had on them raised, bright-red patches, and also that the joints were a little stiff, especially the ankles and knees. Then he tells you that the next day he was better in the morning, but by the evening again the same symptoms including fresh patches had occurred, and so he came to consult a doctor. If you look at him you will find that he has dull red or livid erythematous patches on the lower extremities, some more erythematous than others, and when you press them the redness disappears. In others the vessels have given way, and therefore there are actual subcutaneous hæmorrhages, and the case is, properly speaking, one of purpura. You will also find that some of these hæmorrhagic patches are clearly, from the colour of the extravasated blood, quite recent; others are older. So that as regards the spots, the essentials are these: that this eruption, partly erythematous and partly purpuric, occurs chiefly on the lower extremities, and comes out in successive groups, so that you can see various colours of the extravasated blood—purplish to begin with, then becoming more green, and finally getting to the yellow-green stage of an ordinary bruise. Then further, on examination, you find that the patient's joints and ankles

and knees are a little puffy, and have fluid in them quite apart from any rheumatic fever. Often, too, the erythema is so extensive that there is considerable œdema of the lower extremity. Gradually this eruption disappears, and the patient gets all right. The eruption is rare on the trunk, and rare on the upper extremities, but it may occur on both if the patient is severly ill; it is almost unknown on the mucous membrane of the mouth and on the tongue, and it is accompanied by a slight rise of temperature, even if there is no rheumatic fever. And, of course, as the patient is a rheumatic subject, it is not uncommon to find that he has a murmur.

Well, when this man came in, the first thing we did, considering that 61 out of 200 cases of purpura are rheumatic, was to say, Is it rheumatic? We decided at once that it was in all probability not, and after getting the history more perfectly we concluded that it was certainly not.

The reasons why we decided so are these. He had not had rheumatic fever when we saw him, and it was hardly likely, as he was now sixty-four, that he was going to have it, because most people who have rheumatic fever have had it long before sixty-four. Neither had he any murmur suggesting that he had had rheumatic fever. Then, too, the eruption was by no means confined to the legs. Again, there was no swelling in the ankles or knees. And very important, showing that the disease was a pure purpura, all the patches were extravasated blood; there was no associated erythema with it whatever. And then, as an almost certain proof, there was bleeding from his buccal mucous membrane, and the mouth had a quantity of blood-clot in it. And so for these reasons we had no hesitation in saying that the case was not one of the commonest form of purpura, namely, rheumatic purpura.

Then again, of these 200 cases of purpura, in nine it was supposed to be caused by Bright's disease. Clinically that is very important to bear in mind. Remember—if you want to be good, practical physicians—that the sufferer from Bright's disease may bleed from anywhere. I am always trying to get you to grasp that fact, and if you do not remember it you will get misled. The most striking instance I came across of that was a schoolmaster who came to me because he had a hæmatoma on his ear. But as I did not see why an apparently healthy schoolmaster should have this, I examined his urine, and found plenty of albumen, and this hæmatoma was the first indication of Bright's disease from which the patient was dead in less than six months. Do remember, therefore, that hæmorrhages may occur anywhere in people with Bright's disease.

Another striking instance in point. Patients may suffer from chronic Bright's disease, the first indication of which is hæmoptysis.

Another out-of-the-way bleeding that people with Bright's disease get is that they may bleed from their kidneys or their bladder. Several times I have known students make mistakes, and because the urine contained a lot of blood, entirely overlook the fact that the patient had Bright's disease and the blood was coming from the bladder. The reason that these results of Bright's disease are introduced into the present lecture is that the London Hospital shows that nine out of 200 purpuric cases were caused by bleeding into the skin from Bright's disease. We examined the patient's eyes, heart and pulse; we had no opportunity of examining his urine, he died so soon. But we had no evidence whatever that the patient had Bright's disease.

Then the London Hospital figures show that eight out of the 200 had heart disease. Well, that need not detain us a minute, we examined the patient's heart and he had no evidence whatever of disease of it. You will not be surprised that purpura occurs in heart disease when you remember that extreme backward pressure causes nutmeg liver. At the last clinical lecture but one I showed you a liver full of extravasations of blood from backward pressure of heart disease, and patients thus affected may be purpuric.

Then six out of the 200 suffered from some form of anæmia. Probably they were mostly cases of pernicious anæmia, for you all know that people with this are liable to all sorts of hæmorrhages. This patient did not look as if he had pernicious anæmia. And then we examined the blood and did not find any of the blood changes which you would have expected had the case been one of pernicious anæmia.

We come to another thing. Out of the 200 cases, six were examples of scurvy. That is because the London Hospital is close to the Docks. There are more docks on the north side of the Thames than on the south, so that we do not get many cases of scurvy here, and cases that would come here are intercepted at the Seamen's Hospital at Greenwich. It is of great interest to mention scurvy, because one or two of the men who saw this patient first considered that perhaps he might have scurvy. It is not the first time that patients suffering from purpura hæmorrhagica have been supposed to

be suffering from scurvy. I was at Dreadnaught Hospital for some time and saw a good many cases of scurvy there, and so rare is the disease that the only use to me of the knowledge I acquired there has been to prevent the mistake, such as this, of calling a disease scurvy when it is not. When he has scurvy a man may be bleeding from his mouth and he may have purpura, but the test of a case of scurvy is the peculiar sponginess of the gums. Those who first looked at this man thought that his gums were spongy, but when we got him into the ward we were able to satisfy ourselves that that was not so. The apparent sponginess was due to the fact that there was a quantity of blood-clot sticking to the teeth, and the gums were but slightly swollen, whereas, in scurvy the gums, particularly the lower, swell up so that they hide the teeth. On several occasions in cases of scurvy I have seen the gums so swollen that, in order to make sure there were teeth there, you had to pass your finger along the upper line and feel the teeth in the depression of the swollen gum. If this patient had had scurvy, and had been as bad as he was, it is improbable that the sponginess of the gums would not have been very well marked. This point alone was enough to put the case out of court as regards scurvy. The most common seats of hæmorrhage in scurvy are in the muscles of the calf and under the tibia in front. We felt these parts and there was no blood tumour to be felt. I have known clots of blood in the periosteum over the tibia so marked in scurvy that careless observers have thought they were syphilitic nodes.

The next thing is privation. That is a common cause of purpura. If people get starved, very often they get a little purpura, but they do not bleed from the gums and mucous membrane as this patient did. This patient gave no history of having fed insufficiently.

Then four of the 200 cases were cases of tubercle. That is really the same as privation. People who are excessively wasted are liable to bleed into their skin, but not from their mucous membrane, and there is nothing like the amount of hæmorrhage which characterises the piece of skin which I have shown you.

The next group is perhaps the most important. Three were due to drugs. Some drugs will produce actual extravasation of blood under the skin, but fortunately for us they are few. The most noteworthy is iodide of potassium, and the susceptibility of some people to it is quite remarkable. A case is recorded of a child, one and a half years old, a miserable, sickly child, who got a purpuric eruption as the result of taking two or three grains of iodide of potassium. The form of purpura that comes from iodide of potassium consists of extravasations of blood chiefly marked on the legs and arms and around the hair follicles. All I can say to help you to diagnose it is, that, when you get a case, always ask whether the patient is taking any drug. The curious thing about this form of purpura is that some people who are liable to iodidic purpura do not get it when they have ammonium or sodium iodide, but only when they have potassium iodide. If you know a patient to be a purpuric subject, on no account prescribe iodide of potassium, or do it very gradually.

Another drug which produces it is chlorate of potassium, but this is now only of historical interest. About thirty years ago it was thought to be a specific for diphtheria, and it was given in enormous doses, and many children were killed thereby. Therefore, this drug is of historical interest, and it is also of physiological interest because of the blood changes which it produces; but symptoms of poisoning by it have little clinical interest for it is now given in such small doses, and we have better treatment for diphtheria. Rashes produced by other drugs are so rare that they need not detain us.

Well, then, two of the patients in the list had pyæmia, and two are classified as having endocarditis. There is not much to say about these. It is common knowledge that in pyæmia or malignant endocarditis, you are liable to purpuric patches about the skin. The explanation is this; minute emboli are jammed into the arterioles of the skin, and you know that pathological result of an embolus is often to produce hæmorrhage in the region of the artery beyond the spot at which the artery is blocked. If we had time I think I should be able to show you that we are quite in the dark as to why that should occur. Nobody would guess that it would take place. You would say to yourself, "Surely a hæmorrhage ought not to occur beyond the spot where the artery is occluded." Nevertheless it does.

Two of the cases in the list were congenital syphilis, but that does not bear upon the case now under consideration. Two were alcoholic subjects. There was no evidence that our patient suffered from alcoholic excess, but you must not forget that sufferers from cirrhosis are liable to purpuric spots under the skin. Two cases were due to injury; that was easily excluded in our case. The fact that two cases were entered under the head of convalescence did not bear upon our patient.

Then one was due to malaria. A malarial patient might bleed profusely, but our patient had not had malaria.

Nor is it surprising that some of those cases of purpura were associated with rickets. Rickety children are so miserably underfed that they really fall under the heading of *privation*. I think a little purpura in rickets is by no means uncommon.

The proportion represented by the next group must be much below the mark, because but few cases of whooping-cough go into a large general hospital, but purpuric spots are quite common in whooping-cough. They are attributable merely to the violent paroxysm of coughing.

The next cause, cirrhosis of the liver, is very important, and I am surprised that only 1 in 200 was found; I should have thought it would have been more. I have often urged that there is a good deal to be said for the view that cirrhosis of the liver should be regarded as a general disease, of which the condition of the liver is merely a part, as cirrhosis of the kidney is a part of Bright's disease, and the fact that cirrhotic patients are liable to get purpura shows something in favour of that view. Anyhow, you will find it of importance to remember, clinically, that people with purpura to a mild degree might be suffering from cirrhosis. I remember being asked to see a patient with purpura, in whom the cirrhosis had been entirely overlooked. Probably alcoholism in some way produces degenerative changes in the minute arterioles, and so the blood gets through. In our present case the purpura was so extensive that cirrhosis as a cause was out of the question. People with cirrhosis do not bleed so extensively from their mucous membrane.

The next cause is extremely interesting, and it was much discussed at the bedside of our patient. Out of the 200 cases there was one in which the purpura was caused by hæmophilia. This is a disease that I should like to tell you something about, because it is so rare. The patients are very liable to hæmorrhages from any part of the body, and they get also a peculiar condition of joint. Hæmophilia never occurs in women, only in males. It is most curiously hereditary. What I mean by curiously hereditary is this. Supposing a man has several children—say, two females and two males. Now, both these male children may get hæmophilia, whereas neither of these females will get it. But these female children marry, and we will suppose that each of them after marriage has one male and two female children. Then the male children may have the disease, and the female children will not. So you see it is most curious how the disease is transmitted through the woman to the male, but the woman never suffers from it herself. For any of you who are interested in discussions on heredity, it is a most interesting fact to bear in mind that any explanation which may be given for heredity would have to account for the possibility of such a thing as this. There are two or three other rare diseases which may be transmitted in the same way, but this is by far the most extraordinary. The instance which I gave by way of illustration was a very striking one, but remember it does not follow that every male child of a family will have it. There may be, say, four male children, and only one of them suffer from hæmophilia. But in the event of any of the three males who have not got it marrying and having a daughter, and she afterwards marrying and having a son, this son may develope hæmophilia.

It did pass through our minds whether the patient was suffering from hæmophilia. Before telling you the reasons that he was not, I will give you an account of the disease. The bleeding that people affected with it suffer from may occur at all ages, but is usually first noticed in childhood. Many deaths have occurred owing to circumcision among Jews suffering from hæmophilia. The bleedings are of two classes. Some are spontaneous, such as epistaxis, bleeding from the lips and gums, bleeding under the skin, and hæmaturia. On the other hand, any injury, however slight, may cause bleeding, which sometimes is quite fatal. For instance, I saw a little boy who was known from the family history to be likely to be hæmophilic, and the excessive care was being taken with him, as it always should be with hæmophilics. He was kept at home from school, and one day he was playing in the garden and fell on some tiles that bordered the gravel path. In falling he hit the lower part of his back, and although the fall would have been to most children quite trivial, when I saw him he was paraplegic, and had incontinence of urine. He developed cystitis and died. The slight blow, no doubt, had caused hæmorrhage into his spinal cord and so resulted in his death.

And then one very striking thing is this: these patients are particularly liable to bleed into their joints, especially their knees, and that without any apparent cause. They get repeated bleedings there, and the result of the repeated bleedings is, that the cartilage gets torn away in time by the extravasation of blood, and finally the torn cartilage and the periosteum

become eroded, and the joint ultimately becomes like a joint affected with rheumatoid arthritis. A large number of people affected with hæmophilia get this joint trouble. Twice I have known much turn in the recognition of joint disease in hæmophalia. There was a nephew of a medical friend of mine whose mother got a letter from the boy's aunt, who was in some foreign town with him, to say that the boy had got a swelling in his knee-joint, and an examination had been made by the local doctors, with the result that they had determined to excise the joint. But the mother postponed the operation until his uncle, my medical friend, had been communicated with. It so happened that my friend, knowing the family history, thought it possible that his little nephew might be a hæmophilic, and so he wired back that the operation was not to be done. It turned out that the child was a hæmophilic, for he subsequently passed a quantity of blood in his urine, and it also turned out that the trouble in his knee was due to his hæmophilia. There is not the slightest doubt that the operation would have killed the child. Any ordinary operation for children in that boy's condition is absolutely out of the question. A child with hæmophilia, if operated upon, will probably bleed to death.

I remember a young man who had been treated for chronic rheumatism. The suggestion had been made that his knee trouble was gonorrhœal, but the disease turned out to be the condition of knee not uncommon in hæmophilia, and the mistake was solely owing to the fact that the doctor had forgotten that the effusion into the knee might be a blood effusion. So do bear in mind that possibility in all obscure cases of effusion into the knee. "But surely," you say, "discoloration shows the effusion to be hæmophilic!" That is not usually so. The bleeding in a hæmophilic knee often occurs chiefly in the synovial membrane, and is not sufficient to produce any discoloration of the skin covering the knee.

Well, having discussed at the bedside of our patient the point as to whether he was suffering from hæmophilia, we found no evidence of it whatever.

Varicose veins and peripheral neuritis occur next on our list, but they were not present in our patient nor would they explain such severe and universal purpura as he had.

There are three varieties of purpura which do not occur in this list. One is a variety that I have never seen. It is called Henoch's purpura, and is a very rare disease that occurs in childhood and is very fatal. The purpura takes place in various parts of the body and may be accompanied by arthritic swellings and is associated with colic, vomiting and diarrhœa.

A second is the purpura which occurs in cases of multiple sarcomata. This you will find described by Dr. Fagge; the recognition of it is very important. The third variety of purpura not mentioned in the list is that associated with specific exanthems, of course you do not see these cases in a general hospital, but you may see them in a fever hospital. A small-pox rash, a typhus rash or a scarlet fever rash may be severe enough to be accompanied with actual purpura.

Well then, we come to the last group. Of the 200 cases, 68, I am sorry to say, were unexplained, and as we have not yet diagnosed our case, our case will fall under that heading. In these 68 cases the pathology was quite obscure, and many of them, no doubt, were instances of what I am going to describe to you to-day, and what our patient had, a disease called purpura hæmorrhagica. It is an exceedingly bad name because all purpura is hæmorrhagic. Purpura means the extravasation of blood under the skin. A better name, perhaps, is one that was formerly more used than now, is morbus maculosus. It is obviously a name that expresses the disease and as this was described by a German physician named Werlhof, in 1775, it got dignified by the name, morbus maculosus Werlhofii.

It is a disease which occurs rather more frequently in men than in women, and of which the great characteristic is a number of purpuric spots scattered all over the body underneath the epidermis. In addition, the patients are very liable indeed to bleed from the nose and the mucous membrane of the mouth. I pointed out to you, when I described the condition of our patient, how he was bleeding from the mouth and into the skin. The hæmorrhage is often very well marked under the conjunctiva and on the penis and scrotum. We looked for it in these places, but we did not find it. The blood extravasation may be so extreme that the skin may slough. I think, had our patient lived, there is very little doubt that some of the lining membrane of his mouth would have sloughed, there was such a large hæmorrhage just inside it. Then, too, the tongue may likewise slough, and I think it is very likely that our patient's tongue would have sloughed.

With regard to the state of the blood. Very often people have described bacteria in the blood in this disease and some people have thought that bacteria are the cause of it, but a

great many people cannot find them. Dr. Bryant examined blood from our patient, and he tells me it is perfectly sterile. And, as far as I know, the best observers have found the blood in these cases sterile. So that the probability is that those who report bacteria have accidentally contaminated the blood before obtaining cultures from it.

Another thing about the blood, and what you would expect, is this; because the patient bleeds he has got fewer corpuscles than he should, and his hæmoglobin is reduced. Experiments on animals, and also observations on people who have been bled, show that the fluid part of the blood is very quickly replaced—within a few hours after severe hæmorrhage, but the corpuscles are not replaced until later. Hence, when you examine the blood of these patients, you find that as the corpuscles have not yet been made up again, although the fluid has, the blood itself is very fluid, and the corpuscles are considerably reduced in number, and, of course, the hæmoglobin is reduced proportionately. There is nothing abnormal about the corpuscles in their shape, or staining, or otherwise. The corpuscular reading is 40, or 30, or 20 per cent., according to the severity of the case. The hæmoglobin reading is the same. So that the colour index of each corpuscle is perfectly normal.

The eye changes that may take place are simply due to hæmorrhages which occur in the retina.

The patients often show a little fever; they would get more were it not that the bleeding tends to keep the temperature down. Our patient had a temperature of 99·4°, which was very considerable considering the amount of blood he lost. So many anæmic conditions show a rise of temperature that probably there is some common underlying cause, but what it is nobody has been able to satisfactorily suggest; a rise of temperature is usually seen in leucocythæmia and pernicious anæmia. Occasionally sufferers from purpura hæmorrhagica have a little albumen, quite apart from any blood in the urine.

Occasionally the hæmorrhage is very severe indeed, as in this case; the man was dead within a few days. The name *malignant purpura* has been applied to cases as severe as this.

With regard to the prognosis it is very difficult to tell you anything, because obviously a man liable to bleed from any part of his body may at any moment bleed into some part where hæmorrhage will kill him, and indeed this patient died from hæmorrhage into his brain. I have lost three cases of purpura—this one from hæmorrhage into the brain, another one in the same bed many years ago also with hæmorrhage into the brain, and one that died from profuse hæmorrhage from the kidney. But if you tell the friends that, barring accidents, the patient will get well, you are usually right, for unless the sufferer from purpura die from hæmorrhage, generally speaking, he slowly but gradually recovers.

Next we come to treatment. If the patient is bleeding from his bladder, or from his kidney, do not give him turpentine; it will only make the bleeding worse. But if he is not bleeding from the bladder or kidneys, you may give some turpentine. Many people think it is a good hæmostatic. Personally I am so afraid of giving it lest there should be a tendency for blood to come from the bladder or kidneys, that we did not order it in the case of this man; we had no specimen of his urine. If the bleeding from the kidneys is severe, the best thing is to put an ice pack over the loins. If you decide not to give oil of turpentine, give chloride of calcium. I do not know that these people bleed because their blood is in any way deficient in coagulative power, but probably it is beneficial to make the blood as coagulable as possible, and chloride of calcium in blood increases the ease with which it coagulates. You can give the patient 10 or 15 grains every four hours in a little water. I need hardly add that the patient should be kept quiet in bed, and if the blood-clot in the mouth is decomposing you should keep that cavity sweet by some antiseptic such as 1 in 1,000 of formalin. That is all the clinical part.

Now we come to the post-mortem, to see if our diagnosis was correct, and we found, as we expected, that the man had undoubtedly got purpura hæmorrhagica. He was bleeding from every part of his body. You have seen the bleeding into the skin. I showed you that piece of mucous membrane of the mouth with the blood-clot attached, and I showed you the tongue. If after the lecture you come and look at the specimens you will see other hæmorrhages at the back of the tongue, under the mucous membrane of the mouth, and you will see bright red hæmorrhages under the mucous membrane of the trachea, showing how bleeding has occurred right down the respiratory tract. But oddly enough, there is no evidence at all that bleeding has taken place into the lungs.

Taking the heart next, you can see a hæmorrhage (here) under the pericardium; it shows beautifully. Here is another one, and if you look at it afterwards, you can see that the

hæmorrhage there is quite deep, extending well into the cardiac muscle.

The patient, you see, had bled a little into the kidney, but not much.

Then here is the œsophagus and you can see a considerable livid hæmorrhage under the mucous membrane of it, showing that he was bleeding there.

Then here is a piece of the intestine, and there are several small and one very large hæmorrhage in it.

And now we pass on to the largest of all the hæmorrhages, taking the bladder, and here is an enormous one under the mucous membrane of the bladder. It is, as you can see, a most striking specimen.

But I think, good as that is, there is even a better instance here. Just look and you will see an enormous number of hæmorrhages under the mucous lining of the stomach.

Thus this case is one of the most typical cases of purpuric hæmorrhagica that one could possibly wish to see.

Well now, turning to the brain, you easily see that the diagnosis which we made, that the patient died from cerebral hæmorrhage was correct.

You can see, before I cut into the brain, a certain amount of blood oozing from the base of the brain, owing to the large quantity inside. The lecturer having now cut into the brain, continued: There you see the blood-clot filling up the whole of the interior of both lateral ventricles. There is blood-clot also in the anterior cornua and the descending cornua, and it has torn through the septum lucidum. Perhaps if we cut the brain transversely, we make out a little better where the hæmorrhage has come from. This having been done, the lecturer said: It is all so torn up that it will be quite impossible to form an opinion as to where the exact spot is at which the lesion took place.

That shows you very well how the brain may be torn up by a hæmorrhage, and you have had an instance of death from this cause in purpura hæmorrhagica.

Papers by Guy's Men.

Aneurysm of the Renal Artery. By Henry Morris, M.B. Lond., F.R.C.S. Illustrated. — *Lancet*, 6th October.

Two Cases of Renal Surgery. By Lieut.-Col. Joshua Duke, I.M.S.—*Lancet*, 29th September.

The Students' Club Dinner.

The first evening of the winter session is ever held sacred to the celebration of the annual dinner of the Students' Club. Seven o'clock, therefore, on October 1st found Dr. Hale White, the treasurer of the Club, presiding over a company, which, to use a well worn formula, was at once very numerous and thoroughly representative. As a matter of fact, one hundred and three is the number that sat down according to the official record. Of these, the presence of two excited more attention than ordinary, Mr. Cosmo Bonsor and Mr. Fripp, the latter making his first appearance at the hospital since his return from South Africa, and adding in no small measure to the interest and success of the evening. There was a departure from the precedent of former years in that the dinner was not followed by the first meeting of the Physical Society. This innovation cannot but be hailed with delight: not only was the ingestion of an excellent dinner carried out in more leisurely fashion, but its digestion was made the surer by the dreamy tones of violin and the sonorous notes of vox humana.

Of the menu itself, it were profane to speak in this place: suffice it here, that the ingenuity of its composition was only equalled in the manner of its execution. My function is it rather to treat in more detail the intellectual fare provided by the several speakers who in turn delighted the company.

It was exceedingly interesting to hear Dr. Hale White, one of the original founders, speak of the small beginnings of the Club and of the difficulties its promotors had to face; how its tender years were passed in the library passage; how it sojourned after this in what is now Mary ward; how finally after its struggles it entered into possession of its present rooms in 1882. What, he went on to ask, are the advantages that accrue to members of such a Club as this? To freshmen he would venture, in the first place, to point out the material advantages—as a place to lunch preferable to Lyons': in the next place it provided opportunities of learning how to get on with one's fellows and of cultivating that spirit of *esprit de corps* so peculiarly the property of Guy's men. "Such a Club as this," he concluded, using Dr. Johnson's words, "should be an assembly of good fellows meeting under certain conditions; where the company is both numerous and miscellaneous; where the terms are lax and the expenses light."

No less interesting was Dr. Taylor, who proposed the health of the Treasurer of the Hospital, *Si monumentum requiris, circumspice*—in the last four years what changes in structure had the hospital not seen? At the gate the new iron archway, in the colonnade the new pavement, in the quadrangles the forests of young trees. He regretted the architecture of the new buildings, and above all, the transplantation of the trees in the park.

In his reply, Mr. Cosmo Bonsor expressed the pleasure he always felt at coming to the hospital. The major part of his work, as treasurer, consisted not in superintending either the staff or the students, but in acting

the beggar to procure the still much-needed funds. To be a beggar suggested the "absent-mind" and Mr. Fripp.

Mr. Fripp said that he did not know how to thank them enough for the very kind way in which they had received the toast of his health and for the hearty welcome back that they had that day given him. They could, perhaps, imagine how proud and pleased he was to go out to Africa to help found the Imperial Yeomanry Hospital, accompanied by such a large contingent from Guy's, but he did not think that it was possible for them to imagine how very glad he was to be back at his own work again. The Guy's contingent on the staff of the Imperial Yeomanry Hospital had all, sisters, doctors and students, alike, done marvellously well. Delighted as they had all been to go out to Africa, and happy beyond compare as had been their large party at Deelfontein, still they were nearly all of them just longing to come home again, and some of them, including Mr. Bruce, were already on the sea. Throughout the length and breadth of the land, the hospitals, when he left, were little more than convalescent camps with only a serious case here and there, and there was a general feeling that the end had come and a very general envying of those who were fortunate enough to be able to get home at once. The Imperial Yeomanry Hospital had broken a deal of new ground and many people in a position to judge of the organisation and management of hospitals, had expressed to him the hope, in which he very heartily concurred, that from the demonstration which it had been enabled to give of the way that modern scientific methods could be introduced into the service of the sick and wounded in time of war, there might spring so widespread an appreciation and adoption of those methods throughout all military hospitals that in future wars a closer approximation might be attained to the ideas and methods as carried out in the large civilian hospitals. The hospital at Deelfontein might fairly be called an offshoot of Guy's. In its equipment, in its co-ordination to the complex conditions it had to work under, in its administrations and in the methods employed in its surgical and medical divisions, he and Dr. Washbourne (who was still out there and whose experience in the treatment of typhoid fever had proved of the greatest possible value) had endeavoured, as far as possible, to copy the model of Guy's. Lieut.-Col. Sloggett, R.A.M.C. had proved himself just exactly the right man for the difficult position of Commandant. It was a difficult position, for there were a great many points in which the "running" of such a hospital was a more complicated matter to manage than in a purely military hospital. Indeed, there was nothing about the Imperial Yeomanry Hospital which was in any sense military except two things. Firstly, the military character of the patients and subordinate staff, and, consequently, the method of maintaining discipline; and, secondly, the method of obtaining supplies out of the Army Service Corps. The good reputation which the hospital had evidently earned was due to the employment of ordinary common sense backed up by modern ideas of cleanliness, and by ability and energy on the part of the ladies' committee in London, with the Countess Howe at their head, who, while always willing to fall in with and to rapidly put into effect any suggestions which were made to them by those whom they had honored by choosing as their professional advisers, had not, and he was glad to have this opportunity of emphasizing the point, even thought of embarking upon the luxurious paraphernalia and extravagant expenditure which had been attributed to them by some people who were jealous of the success they had achieved. The fact was there had been no unnecessary expenditure. True, money had been spent in several directions which were novel, and which were considered open to criticism by those who were only used to the old form of hospital. For instance, specialists in ophthalmic and dental surgery as well as in X-ray work had proved a great success, and so had the vastly increased staff of nursing sisters, and the presence of a physician. At the time when the staff left England last February, four times as many sisters were taken out as were allowed to a similar sized military hospital, and their services proved so valuable that ten more were cabled for and sent out shortly after, and the immediate result could be seen from the statistics of the hospital, which show a remarkably small percentage of deaths among the enteric patients. It was very gratifying that this policy of increasing the nursing staff had at once been copied in all the military hospitals. Had it not been there is no doubt the losses from enteric would have been still higher, for, as everybody knew, good nursing was of inestimable value in that disease. Other novelties were the extensive laundry plant, the large steam disinfector, and the large filter, which were taken by this hospital for the first time on foreign service, and which were all worked by the same steam engine. Then again, they made their own soda water under medical supervision on the spot, and there was a supply of compressed gases in iron cylinders, including laughing gas, oxygen, and carbonic acid. Every one of these innovations was a great success, and in his opinion, so far from being in any sense extravagant, they all ought to be incorporated in the equipment of large base hospitals in the future whenever possible. Though the work has been hard and the conditions of life somewhat rough, yet the staff at Deelfontein had no hardships to undergo. It was always a sure proof that one was enjoying a phase of one's life if one was sorry to leave it, and glad as he now was to be back at Guy's, he found it quite a sad moment when the time came for parting with this model hospital and the karroo. "Tommy" was a most refreshing patient to work for. He wished he might never have to deal with any less easily-managed, less plucky, or less grateful class. But eight months was a long absence, and all likelihood of any considerable number of surgical casualties occurring after the war had degenerated into widely-scattered policing movements, he thought it was his duty to get home in time for the work of the winter session. During his travels in Africa

which extended over six thousand miles of railway journeying, he had met over forty Guy's men, and he knew of thirty more in the non-combatant ranks, to say nothing of those who had gone as combatants. Out of these seventy Guy's doctors, no fewer than eight had died in Africa serving their country and their Queen—a mortality of over eleven per cent., which being about double that of the total mortality in the combatant ranks of the army, was so high as to point very clearly the truth of Dr. Conan Doyle's remarks about the arduousness of the service, and the danger run by those sisters, doctors and orderlies who work in hospitals—even base hospitals, which, because far removed from the field of battle, are wrongly supposed to be safe. He ventured to say that he did not think this point had hitherto received quite the appreciation it deserved. Another point which he would have liked to have seen better appreciated, was the generosity of the Boers in permitting our besieged garrison in Ladysmith to have a safe pitch for their 1900-bedded hospital at Intombi Camp, and to run a train backwards and forwards to it each day from Ladysmith. Intombi was just at the foot of one of the hills held by the Boers, and, but for their generosity in lending it for the use of our sick and wounded, the latter must have been cooped up in the little town of Ladysmith and without a doubt their presence must have so far increased the overcrowding and the load our gallant defenders had to bear as to have rendered it impossible for them to hold out till the end of February. In concluding, Mr. Fripp again thanked them for the extremely kind welcome home which they had given him, and also he said he wanted to take this opportunity of offering his thanks, firstly to the Treasurer and Governors for allowing him to absent himself from Guy's Hospital for so many months; secondly, to his colleagues on whom an increased load of work had fallen during his absence; and, thirdly, to all those old friends of his who, while unable from one cause and another to themselves join the favoured few whose more fortunate circumstances had allowed them to go out to Africa, had by many acts of kindness repeatedly reminded him of their goodwill and kind thoughts.

Dr. Hale White's health was proposed by Mr. Durbridge, the president of the residents, who spoke of him as founder of the club, as a physiologist and as an author. The fevered body took comfort in the thought of a controlling heat centre: the anguished mind remembered, perchance not in vain, its materia medica.

Such a brief resumé as the above gives, I fear, no notion of an interesting series of speeches, each of which seemed in turn more entertaining than its predecessor. During the evening Messrs. Parrett, Claxton and Allport sang, while Mr. A. Soper played the violin.

In addition to those mentioned already, the following members of the Staff were present:—Drs. Taylor, Stevenson, Pitt, Perry and Bryant, and Messrs. Golding-Bird, Brailey, Symonds, Dunn, Fagge, MacGavin, Ormond, Swan and Eason.

Chapel News.

The Harvest Festival is fixed for Sunday next, October 14th. Holy Communion at 7 a.m. and 8.45 a.m. 11 a.m., Matins and Sermon—Preacher, The Rev. W. L. Vyvyan, Charterhouse Missioner. 7 p.m., Evensong and Sermon—Preacher, The Rev. C. P. Greene, Rector of Clapham.

In future there will be a celebration of the Holy Communion at 6 a.m. on the first Sunday in the month, in addition to the celebrations at 7 and 8.45 a.m.

Nursing News.

Matron's Office.

On Thursday, September 27, the Probationers' Examination in Surgery was held in the Medical School Building. The following Candidates were successful in satisfying the Examiner:—Probationers A. Allen, Anderton, Bardsley, Bishopp, Blasson, C. Brown, Byrne Carter, A. Collins, Chittock, Cope, Cook, E. Crowe, F. Crowe, Dann, M. Davis, Dingwall, Dixon, Earp, Eldridge, Essex, G. Field, Guthrie, Hecks, Hills, Hooper, Hopkins, Horsepool, Iszard, Jackson, Jenkins, Lavy, Layng, Leslie, Lewin, Maddison, Manning, Millidge, Milman, Morrall, Neale, Norman, Parr, Perriam, Pettit, Pickles, Powell, P. Ray, Ripley, A. Rogers, M. Rogers, Ross, G. Russell, Salway, Savage, Stokes, Street, R. Thompson, Towsey, Tweedie, S. Ward, H. Walker, Wilkinson, Windemer, Winstanley, Witchell, A. Wood, L. Wood, Yates.

On Thursday, October 4th, the Probationers change of wards took place.

Sister Miriam's Course of Lectures on Nursing to Probationers commenced on Thursday, October 4th.

On October 8th, Nurse Brooker, Head Nurse in Queen Ward, left the Hospital on completion of her three years' training, and Probationer Stanyon was appointed Head Nurse in Queen Ward in her place.

Pass List.

University of Durham.

The following Degrees have been conferred:—

Doctor in Medicine.—E. E. Frazer.

Doctor in Medicine (Practitioners of fifteen years' standing).—W. H. Crosse, R. A. Milligan.

Bachelor in Medicine and Surgery.—S. C. Clapham, H. C. Sturdy.

THIRD EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE.

G. W. Smith, (Honours Second Class).

Passim.

It has come to our knowledge that we have been offending, unwillingly it is true, but none the less offending, and the manner of it is as follows. With a natural desire to publish good cases, those interesting from their very rarity, and those remarkable for their obscurity, we have not sufficiently recognized that every "case" has an owner, and that the owner is not the clerk who makes out the report. The real proprietor is the member of the staff under whose care the patient is admitted, and to him belongs the right of publication of anything connected with the case. In nine cases out of ten this right is not exercised, but we have unfortunately struck upon the tenth, and have permitted the publication of cases which were in course of publication elsewhere by their rightful owners. As has been pointed out, mistakes of this nature can be avoided by the author of the abstract first submitting his copy to the surgeon or physician with whom the treatment lies; and not only will unintentional piracy be avoided, but the article will be made additionally valuable from the fact that it will have received a hall mark of accuracy by such a course. In future, therefore, we must ask correspondents to observe this rule; it will not prove irksome, and should in the end be provocative of much good.

"Going-off night" must always be an evening of mixed feelings, for it marks the beginning of a new epoch for some, and for others it rings the curfew of their hospital life. And lest these two elements should spoil the effect of what ought to be a congenial gathering, there is a marked guest element at the Residents' dinner which opens the evening, and the same guest element leaves a broad mark on the subsequent proceedings of the night. These going-off dinners are curious if only in their customs, in their speeches, brief, but to the point, and in their secret publicity by which the new President and his Vice-chairman are elected during the very dinner, under your very nose in fact, with great conspiracy, and the much shuffling of folded papers, and then after the anxious wait, the result is announced amid the applause of the expectant multitude. This year Mr. Durbridge went into first place, and the yells of delight which greeted his election must have awakened him from his fevered dreams as he dozed "with a temperature" in his room across the quadrangle. Mr. Osborn's election to the vice-presidency proved an equally popular choice, although a matter of surprise to many, and most of all, to himself.

Our attention has been drawn to a notice lately posted in the colonnade with regard to revision classes for the Finals. The chief change therein indicated is the greater importance given to the test examinations which a man must pass before he can be admitted to the classes. Some people might think you ought to be taught before you are examined, but the school authorities have decided, at any rate as far as "revision" teaching is concerned, that a student must show that he has some knowledge to be "revised" before this important proceeding is taken in hand. These exams will in future be oral as well as written, and one of the senior staff will be associated with the teacher of the revision classes and with the registrar in conducting the examinations.

We understand that the "test" will be a sort of "dress rehearsal" of the public examination for which the men are preparing. The details are not yet definitely settled, but it is probable that the *vivâ-voce* examination will be public. At any rate it is likely that those candidates who have been through the ordeal will be expected to stay and listen to the *vivâs* of their successors. Another change which we think will be generally welcomed is the holding of the revision classes at a somewhat earlier date than heretofore. The next batch will begin early in November and cease with the end of the term before the Christmas vacation. This will make them available for men going up for examinations at the end of December as well as for those who sit in January. It will also avoid running the classes through the vacation, and will give the conjoint men a few days before their examination free for coaching or holiday, as the case may be.

The Students' Club dinner was undoubtedly a magnificent success. It had been skilfully engineered throughout and the grand consummation reflected nothing but credit on those who were responsible for its production. The first appearance of Mr. Fripp after his return from Deelfontein, was arranged for this particular evening, and the reception which he received served as a faint echo of the appreciation in which the Imperial Yeomanry Hospital is universally held. Mr. Durbridge, the new President of the Residents, came out in a new

rôle and evinced talents, as an after dinner speaker, which have hitherto lain dormant. And yet perhaps it is too much to say that his speech was altogether unexpected. When it was known that he was to propose the Chairman's health, those who had heard him give his intensely witty, though apocryphal, account of the Biennial Dinner, were on the look out for something good; and they were not disappointed.

Two old Guy's men have distinguished themselves in different parts of the world and in widely different capacities. Mr. Graham Marshall, whose skill as a water-polo player helped Guy's materially to win the Cup in the Inter-hospital competitions some few years back, has now received the captaincy of the English team in this particular sport. We wish him every success and more power to his good right arm that he may reflect honour on his old school. The other Guy's man has done his duty to his hospital and his profession under the most trying circumstances. It will be remembered that in Lord Roberts' report on the treatment of British prisoners at Pretoria, he commented on the conduct of a medical man in a manner that caused us to blush for our profession. And, then, as an antidote, he gave the highest praise to the untiring efforts and the whole hearted devotion of a Boer surgeon, Dr. Peter Haylett, whose work on the prisoners' behalf could not be over estimated. Dr. Haylett has proved that he could live up to his old school motto even in times of national crisis.

The Physical Society opened in fine fettle last Saturday with an extremely interesting paper by Mr. Curtis on an "Ornithological Cruise in the Polar Seas." The title was not such as would attract the average non-scientific man, and it must be confessed that the bulk of the members of the Physical Society are of this class, but Mr. Curtis handled his subject with considerable skill and not a little dry humour, talking well down to our level without making it obvious that he was doing his best to avoid puzzling us. The lecture was illustrated by a number of photographic lantern slides which limited, as Sir Samuel Wilks pointed out, the lecturer's flights into the realms of fancy. The original intention was to use the arc-lamp projector in the physical building, and preparations were made accordingly. Fortunately an inherent distrust in these new-fangled things led the Society to appeal to Messrs. Stanley & Co., and they lent an oxy-hydrogen apparatus as a stand-by in case of accident. The electric lantern gave up the ghost at the first picture and the rest of the illustrations proceeded without hitch on the borrowed lantern. Afterwards Mr. Curtis demonstrated a number of valuable specimens of bird and vegetable life which he had collected during the expedition.

Upstairs, in the physiological rooms, had been arranged an excellent display by Messrs. Down Bros., Crouch, and Grattan, of their various departments, while Mr. Shenton had a very fine collection of skiagrams on exhibition. Perhaps most credit is due to Messrs. Downs for their tables of surgical instruments, all of them of the very latest and best, and for the number of expert explanators who seemed to take a real delight in showing you the beauties of the many highly ingenious mechanical contrivances. It was very interesting to watch the young and the old Guy's man each doing his best to appear thoroughly familiar with surgical equipment, but occasionally furtively eliciting information on the numerous instruments that were beyond his ken. As is usual on these occasions, Mrs. Batten's exhibit attracted a number of interested spectators, who went not away empty.

Mr. F. E. Fremantle has been detailed for duty on a returning trooper and will arrive in England about the end of November.

Blackheath Football Club has set a worthy example which might very properly be followed by others of our leading clubs. From their surplus they have sent a donation to the funds of the hospital, and we take this opportunity of thanking them for their gift, which is in the true sporting spirit. With the premier Rugger club of the South leading the van, perhaps some of the other famous old teams will be induced to emulation. We can assure them that no better object of their charity can exist, and we might venture to insist with a proper delicacy, on the natural connection which exists between football and hospitals.

The Eastbourne Chair, of which we gave a description in our last issue, may be seen on application at Messrs. Down Bros., St. Thomas' Street, S.E.

The Debating Society will hold its first meeting in the smoking-room of the college on

Saturday the 27th inst. Dr. Pavy. it is expected, will again take the chair The disputants on this occasion are Messrs. Wacher and Thompson, and the subject on which they will wrangle will probably be connected with the immense Conservative majority in the new House. We are not quite sure which man will approve and which disapprove; such a detail as this is immaterial and is probably not as yet entering into the thoughts of either debater. Both are good forensic speakers, and great on side issues, and the contrast between Mr. Wacher's theatrical diction, his ludicrous bathos and his racy humour, and Mr. Thompson's more solid and studied manner, with his crashing retorts and fierce insolence, will be sure to make the evening most delightful to all lovers of wordy warfare. To the freshman we may give a word of advice. Turn up at this opening meeting and don't be afraid of speaking. Do not let your natural modesty and your feared ignorance of the matter under debate prevent you from airing your views, for you will find that four-fifths of the speakers have not the remotest idea of the trend of the subject.

We hear on good authority that a revised and enlarged edition of Dr. Starling's well known "Physiology" is shortly to be published. The proved excellence of the former edition makes the promise of an expanded volume of very great value.

Guy's Hospital Medical School.

The following Entrance Scholarships and Certificates have been awarded:—

Senior Science Scholarship for University Students, £50.—Mr. A. R. Brailey, Downing College, Cambridge, and Mr. S. W. Cole, Trinity College, Cambridge, equal, £25 each; and a Certificate to Mr. D. M. Hughes, University College, Cardiff.

Junior Scholarships in Science.—£150 to Mr. R. W. Allen, University College, Auckland; £60 to Mr. C. M. Wenyon, University College, London; and Certificates to Mr. H. Thomas, Kingsholme School, and Mr. F. H. Lennox-Jones, Latymer Upper School.

Entrance Scholarships in Arts.—£100 to Mr. H. O. Brookhouse, Blackheath School; £50 to Mr. W. H. Dencer, Colfe Grammar School; and Certificates to Mr. G. Cockcroft, Rossall School, Mr. T. B. Layton, Bradfield College, and Mr. G. F. E. Allison, Rossall School.

The Physical Society.

The opening meeting of the Physical Society was held on Saturday evening, October 6th, in the new Physiological Theatre. Sir Samuel Wilks (President) occupied the chair, and there was a strong muster of members.

The President said: Well, gentlemen, the world has rolled round again and found me in the old place. (Applause). I need not remind you that the session has been inaugurated and that you have all been at work for a week already. It would, therefore, be an anomaly for me to attempt to start you now. Hence I have not got up any speech for the occasion, and that, no doubt, will be as pleasing to you as to me. However, it is never too late to do what I have always done—to welcome you to the profession and especially to Guy's Hospital. (Applause.) I think I can do that much better than any of my colleagues. That may appear to be conceit on my part, but it is not conceit if there is anything in the pride of age. However, I can say, from a very long experience, that I can heartily congratulate you and welcome you to the medical profession; and I do so earnestly and seriously. Well, you have got to take your position in society and the human family, and it is said, and rightly, What can be higher than your function, that of attending to the welfare of your fellow creatures? Very few professions can be higher than that. The human body is subject to a thousand ailments; it gets out of its upright position, its normal position, and what you have got to do in your great function of life is to put it straight again. That necessarily involves that you must make a study of the human body and everything about it. And not only that, but you must be acquainted with all those other things which influence the human body. It is influenced in a thousand different ways, and therefore there is a large number of other things which you must also study. All the different branches of science are intimately connected with it, so that you not only have got a high calling but a large amount of work to do of a most interesting character. This was well noticed by a very large number of speakers at the late meetings of the British Association at Ipswich. I observe that a great many remarked how in our profession we are making use of a large number of sciences. Take a great discovery of late years, that of specific diseases due to bacteria. Our forefathers never knew anything about it, and we only know about it through the discovery of the microscope. That discovery is really outside the profession. The same may be said in regard to the ophthalmoscope and to the Rontgen rays, both of which are now made use of in our own profession. When you think, therefore, of the high calling and the number of interesting subjects before you, ought not I to congratulate you and welcome you to a profession like ours? Think of it compared with the occupation followed, perhaps, by one of your brothers in a banking house where he has the ledger before him all day long! There is no comparison between the two things. Therefore,

I say, I can really welcome you to a profession, like our own, so full of interest. I can imagine some of you saying "That sounds all very well, but I entered the profession to get a living." Well, I do not think you did. If you really entered the profession for money-making, you have made a mistake, and I think it is not too late to retire now. (Laughter and applause.) I do not think any of you did enter the profession with that as your sole object. There is plenty of competition in our profession, as in every other vocation, and the best men come to the front and the weak ones go to the wall. There are some twenty thousand doctors in our country, but life is short, and they are dying out, and others must take their place. You have got to take their place. Of course, if a man does not fit himself for his work you know what happens, but there is plenty of room for men who work, if they work honestly and in a straightforward way. Speaking about emoluments, you ought to see clearly the difference between a trade and a profession. A man follows a trade for money-making alone. He knows what the public want, and supplies them with that, whatever it may be, and he gets a return. But to introduce a principle of that sort into a profession is dreadful to think of. A professional man is a man who gives advice, whether it is in the church, or in the law, or in medicine, and nothing is more dreadful to conceive than what one hears of sometimes—that a parson in the pulpit is thinking of himself, of what a great man he is, instead of thinking of his congregation. *Self-aggrandisement.* Or, what is worse still, a doctor perhaps has a patient before him, and is thinking whether there should be an operation, and his first consideration is, whether he will get a good fee. I think that is a dreadful principle to carry out. The first consideration should be to do your duty to others, and then you will get a proper emolument. That is the difference between the professional man and the tradesman. Sometimes you see from the papers that in some poor district of London there was an inquest on a child or some adult. The doctor was sent for and he did not go. He said he could not go unless he was paid, and because they could not guarantee paying him, he did not attend. Of course, he has the law on his side, but then I think it is awful to contemplate that such a principle should be uppermost in the mind of a man who ostensibly enters the medical profession to benefit his fellow creatures. I feel that such a man is degrading the profession. There is a certain district in London where that kind of thing is so well known, that even the joke which is made of it is degrading to us. I am told, for instance, that some of these people say that "*M.D.* means *Money down.*" I do not want to go into questions of medical politics, but I have been very sorry lately to see that organisations exist amongst medical men mainly for these material objects. And more than that, they want the medical council to ask Parliament for protection against certain abuses affecting the profession. I have no sympathy with any of these movements at all. I think the profession is to be raised individually; that is, by individuals doing their duty. A medical man who talks about protection in that sense forgets, I think, that he is an Englishman. An Englishman is known by his independence; he does not go to Government for help. We get up our own hospitals, and so with our universities and our colleges. They have a uniform system in Germany as to the conferring of certain degrees. Some forty years ago, in England, inasmuch as diplomas became unequal in value, it was thought necessary by some that the State should step in, and there was a movement set on foot that those diplomas should all be done away with, and a State examination be given to make them uniform. There was a great outcry at the time from the old colleges and universities against the adoption of any such proposal, and eventually it appeared that the Government itself had not contemplated doing anything of the kind. If one reads the "Committees" of the House of Lords and the House of Commons of forty years ago, in reference to that same thing, one finds that the general feeling was that not a single one of our great educational institutions ought to be touched in any way. And so it was decided that the medical council, as representing all these different educational bodies at Oxford, Cambridge, Edinburgh, and other places, should make a fixed standard of examination, and that they should visit all these places and see that the examination was up to a certain standard, and then those who took diplomas were to be put on the register, and being on the register, they were granted legal privileges. Therefore, you may have diplomas from all these different places, and they must reach the standard set up by the Medical Council. And a very good arrangement that is, but I am sorry to say there are men now in the medical profession who want to do away with that system, and make a State examination. All I can say is, I am sorry for them; they have not a bit of real English blood in their veins. Another extraordinary thing. They would like Parliament to put down quackery. Well, you can go to your butcher and baker, if you like, and ask him for advice. (Laughter). There was a man in Harley Street who died two or three years ago, and some of our aristocratic and wealthy and intelligent men went to that man, and he told them he was a bone-setter, and did not pretend to do anything else. There are men in our profession who would go to Parliament and ask that such a man as I have just instanced, should be put down. I mention all these things so that if you enter the profession you should thoroughly know that you ought to be English in all your conduct throughout life. It is really absurd to see what some of my fellow men in the profession are now doing, and so forgetting that they are Englishmen. You say "It is very hard that men's titles are unequal!" I can't help that. A man wants to be in the Church and his father cannot afford to send him to Oxford or Cambridge, and so he has to be ordained without a degree. He cannot help it. One man is an M.D., and another possesses an inferior title, and so some people would like the legislature to

come in there also. The moral of it all is, that you should look to yourselves. Conduct yourselves in a straightforward manner, and then success will follow you. Do not look for extraneous things to raise you in your profession—money-making and so on. That is all outside; and not only that, it is neither patriotic nor English. Well, gentlemen, let me again welcome you to the profession and to Guy's Hospital. You cannot do better than come here, and that for two reasons. One is, that I believe we offer you every facility for learning your profession. In fact, you have no better means provided in any other place in the kingdom of thoroughly knowing your profession. It used to be so, it is so now, I believe. And then there is something else which you, no doubt, have heard of already. There is a remarkable spirit of *esprit de corps* and enthusiasm at Guy's Hospital which you find seldom anywhere else. (Applause.) Of course this school is comparatively a new school, and every improvement was made by Mr. Harrison, who founded this school, these improvements including an eye infirmary and a museum. The consequence was that Guy's school was founded and went ahead, and such it has continued to do ever since. There are strangers who come here, and they always notice the wonderful enthusiasm that exists in the place. If they go into the wards they see the teachers, especially the younger men, working as nowhere else. The result is that Guy's students learn to believe in themselves, they are very enthusiastic, and they think there is no other school like their own. And so the enemy says that they are "proud and conceited." Well it is just the other side of the case—something like our own praise of what we are doing in Africa, and then we hear what the French say about us. (Laughter.) But still we have this character, and I am very glad we have a character of that sort. Well, now, you come here to be industrious, and then you will have success. If you do not work, of course, as I have said, you go to the wall. Perhaps you say to yourselves, "If that is the case, nobody is loser besides myself." But that is not true. There is somebody who loses besides yourself. You join Guy's Hospital, and immediately you put your name down here you have a duty to the hospital; you are not a free man, you cannot do as you like. You have attached yourself to the place, and you are bound to do it honour in every way you can. I hold that every man is a debtor to his profession; his duty is to endeavour by every legitimate means to be an ornament thereto, as, for instance, in holding a certain position in society, you owe very much to your hospital or to your college, and when once you attach yourselves to Guy's Hospital you must see that you do not in any way disgrace it, but on the other hand, that you uphold it and maintain its good name. I do not know that there are many of you who will take a great place in the medical profession, but the great traditions associated with Guy's Hospital must be handed on, and some of you no doubt will succeed in that direction. I must not take up your time any more than to say that I am very pleased to be here once again. I feel somewhat as Cicero did. As a young man he went to the Forum and he continued doing so up to old age. He used to say, "Rem publicam fovi adolescens non deseram senex." I cannot do better, I think, than end with that. (Applause.)

Mr. Curtis then delivered his interesting address on "Notes from an Ornithological Cruise in the North Polar Seas," a full report of which will appear in our next issue.

Mr. Davies, in proposing a vote of thanks to Mr. Curtis, described the lecture as the most interesting he had heard at the Physical Society. The subject of Arctic scenery, with such photographs as they had seen that night, was always an entertaining one. The philosophy to which Mr. Curtis had treated them was very useful; that in regard to the proper method of killing bears might be of use to any Arctic traveller, whilst the notes on breeding in the Borough, and the methods of delivery in whales, were also instructive (laughter), as also the colouring of the eggs. He (Mr. Davies) thought that anyone who ever thought of accepting the post of surgeon to one of those Arctic trips, should study the bird life and other features of the regions to be visited, for the medical officer of such expeditions was expected to be an authority on those matters. With regard to the flora, specimens of which were exhibited at the meeting, they were the only fauna that one met with in those northern parts. The only other things that he saw when there were a couple of mosquitoes. He thought that they all owed a debt of gratitude to Mr. Curtis for so admirable a lecture and such excellent photographs. (Applause.)

Mr. Dunston seconded the vote of thanks, and endorsed the remarks of the last speaker as to the way in which they had enjoyed the lecture. (Applause.)

Sir Samuel Wilks, before putting the vote of thanks to the meeting, remarked that there was no one present in a position to criticise the lecture, and there might be a good deal of original matter in what they had heard that night. He supposed it would be published. The lecturer had discovered a bay in Nova Zembla, and perhaps some of the flora of which he spoke. At any rate they were all very much pleased to have heard the lecture. (Applause.)

Mr. Curtis, in responding, thanked them very much for the exceedingly kind way in which they had listened to what he had said. In reply to Sir Samuel Wilks he might say that the results of the expedition had been published, and a book had been brought out, entitled "Beyond the Pechean Sea." He did not think anything absolutely new was done in regard to birds, except that new records were obtained of birds that have never been seen so far north before. A good deal of new work was done in the botanical line, especially in Nova Zembla, where a great many interesting species were found. Several plants of particular interest were discovered, more especially the grasses to which he had referred. (Applause.)

Mr. Turner said it was his very pleasing duty to ask them to give Sir Samuel Wilks a most hearty vote of thanks for presiding at their meeting that evening. (Applause). It was many years since Sir Samuel retired from active work at Guy's, but, nevertheless, ever since then he had continued to take a keen and active interest in everything concerning the old hospital and its institutions. (Applause). Every Guy's man was familiar with Sir Samuel Wilks' face, and, still more important, everyone was familiar with the story of his work, his work for scientific medicine, and his work for Guy's. (Applause). On these occasions they were always pleased to see old Guy's men present, and he was glad to see that there was a very good sprinkling of them to-night. Sir Samuel Wilks was an old Guy's man, and stood before everyone as an example to old Guy's men and present Guy's men, of the *esprit de corps* and enthusiasm, and keenness which he had mentioned in his address. Not least among the institutions of the hospital was the Physical Society, and they always regarded their opening meeting as the most important of the session. They had been accustomed for many years past to have Sir Samuel Wilks as their president at the opening meeting, and they hoped to see him in the position for many years to come. (Applause). They were all exceedingly glad to see him, and he asked them to assure Sir Samuel of the fact by according him a most hearty and enthusiastic vote of thanks. (Loud applause).

Mr. Curtis seconded the vote of thanks, and it was very heartily accorded.

Sir Samuel Wilks thanked those present for their hearty applause, and mentioned that the only connecting link he had now with the school was through the Physical Society, and as long as he lived he would only be too pleased to come amongst them. (Applause).

The interesting proceedings then terminated, and the society adjourned to the adjoining laboratories where refreshments were served. Messrs. Down Bros., Crouch, and Gratton, were represented in their respective departments by carefully arranged exhibits, of which Messrs. Down's admirable collection of surgical instruments attracted much attention. Mr. Shenton, too, showed a number of extremely interesting skiagrams.

The thanks of the society are due to Messrs. Stanley who supplied and worked the oxyhydrogen lantern, by which the lecture was illustrated.

Appointments.

Fell, Robert, M.R.C.S., L.R.C.P. Lond., has been appointed Senior Assistant House-Surgeon to the Huddersfield Infirmary.

Plumley, Arthur George Grant, M.B. Lond., M.R.C.S., L.R.C.P., L.D.S. Eng., has been appointed Dental Surgeon to the Clayton Hospital and Wakefield General Dispensary.

Turner, Dr. George, has been appointed, by the Field Marshal Commanding-in-Chief, Medical Officer of Health for the Transvaal.

With the Army Medical Corps in South Africa.

(By Our Special Correspondent.)

(Published by permission of the Director-General of the Army Medical Service.)

Wolvehock Station, O.R.C.,
August 3rd, 1900.

With one exception everything has been going on quietly here for the last fortnight, despite the frequent interruptions to the line. The daily question now at breakfast is, "Where was the line broken last night?" On Friday it was at Amerika siding, ten miles north of Kroonstad; on Sunday it was at Koppies, twenty miles further on; on Wednesday it was near Serfontein, halfway between the two; last night it was somewhere else, but the line was repaired by Kaffirs before the construction party of the R.E. reached the break, so that it cannot have been serious.

The exception to the monotony of life at Wolvehock was one audacious attack on the station last Friday, July 27th. The five hundred Boers or so, who have been hovering about in the neighbourhood doing nothing except to "be on commando" the last month and more, took courage on the evacuation of Heilbron; and, thinking probably that this place, the junction of the Heilbron and main lines, might have been weakened at the same time, they appeared on the horizon. Some young scamp, named J. J. Viljoen, sent in a note under cover of a flag of truce, giving the garrison fifteen minutes to surrender. It ran as follows, according to the translation made for our benefit by a friendly English farmer:—

To His Excellency the C.O. of the British Government at Wolvehock (viz., a captain in the R.I. Rifles).

My Lord

I the undersigned officer of our government of the Orange Free State do hereby give your honour notice to surrender with your troops unconditionally within fifteen minutes. If you will not, remove all women and children, as I shall be forced to take other steps. Reply immediately.

Your Excellency's most obedient servant,

Signed J. J. Viljoen, Commanding Officer.

In the veldt, 27th July, '00.

The women and children and half a dozen sick from the hospital were run down the line half a mile out of the station in the charge of an orderly, and the Red Cross flag was hauled down from the hospital, which was necessarily within only a few yards of the trenches. As there is only one row of iron buildings on either side of the line, all the buildings are close to the trenches; and so the only flag that can be flown in action is a tiny Union Jack bought by your correspondent at the Stores at home for 10d.

However, the defences of Wolvehock were worthy of Mafeking, and neither side had any guns, so that a

harmless interchange of rifle-fire at 3,000 yards went on for half an hour, and the Boers then retreated.

Unfortunately your correspondent was away at the time, having been sent down at half an hour's notice by telegram from the P.M.O., Lines of Communication, to take some sick men down to Kroonstad. In case of necessity the Medical Officer of Vredefort-road, sixteen miles down the line, would have been summoned. The little party of sick in the guard's van, going down to Kroonstad, was augmented at Vredefort-road by the addition of a Boer who had been shot through the thigh a week previously. The wound was supposed to have been a simple flesh wound; but after three days gangrene had set in, presumably from interference with the femoral vein, and the leg had been amputated above the knee. To add to his troubles, the patient amused himself by pulling off the dressings and removing the stitches; and yet his temperature was normal.

All eight cases reached Kroonstad (66 miles in 8 hours) in safety, and were taken over by the P.M.O. of No. 3 General Hospital, which is under canvas just outside the town. No. 3 used to be at Rondebosch, and has been noted throughout as being one of the best managed of the General Hospitals. It is now divided into two sections, one half being at Springfontein, south of Bloemfontein, and the other half at Kroonstad, this half therefore is designed for 260 patients, instead of the 750 which it contains at present. But in accommodation at least, and medical attendance, there is nothing to be desired, and the P.M.O. with characteristic courtesy received the eight new cases without a murmur, although the wire announcing their coming had never reached him. How would the H.P. for the week and the Superintendent at Guy's like to have eight extra cases thrown upon them without warning, when they had already got their beds full three times over?

This left your correspondent free to look after other business. As a daily ride of 20 miles here over stony veldt is more work than can be managed by a single horse in the middle of winter, and as the government horse provided had been lame for a fortnight, it was necessary to draw two horses from the remount yard. The first person met, fortunately, was an old ship-friend, now in charge of remounts at Kroonstad, who promised to find two good horses for the work, but was unable to supply any that day, as all horses available were required as remounts for General Broadwood's troops near Koppies. As a fact, the next batch of horses did not arrive for four days, and your correspondent accordingly had to leave his servant behind; and in the end could only be spared one horse at the time. That horse *en route* narrowly escaped being left behind at Koppies, where he was taken out with others for Broadwood's column and was only re-captured by the vigilance of the faithful servant.

A second duty at Kroonstad, that of buying stores for the mess at Wolvehock, and securing a case of goods for the hospital from the Red Cross depôt, occupied the next morning; a good supply of dried fruit and tinned food, baking-powder, ginger, rolled oats and other edibles for the mess, and corn-flour, shirts and Balaclava helmets, walking-sticks and other comforts for the hospital being secured. It is only by a diligent use of the personal equation, that under the military exigencies of the times, such goods can be conveyed up the line; but they have eventually arrived here complete.

Finally, an old Wynberg colleague, one of the best civil-surgeons sent out to the country, was found in the Grand Hotel, now used as an officers' hospital, lying dangerously ill. At the end of May he had enteric fever, and after no less than seven attacks of hæmorrhage, from which it was thought out of the question that he could recover, he recovered. For most of last month his temperature was normal, he was on solid food, and went out for carriage drives. On Tuesday, a week ago, his temperature rose again slightly, and rose higher and higher each evening, until last Friday he had a regular septic temperature, varying from normal in the morning to 103° and higher at night. He had no signs of perforation—which would be almost impossible in the tenth week of the illness, after enteric and febrile signs had disappeared for a month; but he was evidently suffering from peritonitis. What the cause can have been it is difficult to decide, and there was no indication for operation; but the prognosis must be extremely serious.

Sports were held at the Scottish hospital on Saturday afternoon; and all the available rank and fashion of Kroonstad attended. A terrible accident occurred, however, to mar the proceedings, as in the horse race two riders running neck to neck round the row of biscuit tins, which marked the bend of the course into the straight, stumbled and fell heavily to the ground. One escaped, mounted again and rode in to the finish; the other lay conscious but with blood gushing from his left ear. There could be little doubt of the diagnosis; and he was one of the best of the young Scottish surgeons.

The railway-line was blown up on Friday night ten miles north of Kroonstad, and the first train allowed up after the break had been repaired, was timed to start on Sunday morning at 4 a.m. It was necessary, therefore, to get up at three, and even on reaching the station at four and making oneself comfortable with rugs and a coat in the guard's van, fate ordained that the guard's vans should be changed; and the second guard's van with the train in front of it only left at six, and arrived at Wolvehock at 10 p.m.—a long journey for 66 miles without any food. The driver of this train gave a graphic account of the blowing up of the line near Amerika siding two nights previously. For fifteen years, he said, he had been an engine-driver, and had been afraid of nothing, but this experience fairly frightened him, and he refused to drive any more on that section of the line at night. He was approaching the siding at 1 a.m. on Friday night, when he saw two Boers lighting the fuse of the dynamite charges under the line. He was too close to stop; and, if he had been able to stop, the train would have been at the mercy of any Boers that might be near, perhaps in force. So he turned on "Full steam ahead." Bump, bang, went the cow-catcher against a huge boulder of

stone, laid across the track, but fortunately the engine kept the rails. "Now she's across. When will it blow up? One truck crossed it; two; three; four; — six; — — ten; we must be clear by now." Bang-g-g went the dynamite, but the train was free. The next day the engineers found forty charges, paper packets, in position under successive rails; but only three were discharged.

F. E. FREMANTLE.

Missed Labour from Pregnancy in a Rudimentary Horn of Uterus.

A.D., æt. 29, primipara, was admitted into Queen Victoria ward, on August 29th, with the following history:—

She was married in May, 1899, and from the third week in the following June, till May, 1900, there was amenorrhœa. A flooding, not very profuse, then occurred. The blood was dark, but there were no membranes or clots, as far as the patient remembers. This discharge of blood lasted the whole of May. In November, 1899, she was attended by a doctor for pain in the left iliac region, which readily yielded to palliative treatment. In the beginning of April, about the time patient expected to be confined, attacks of pain came on resembling, according to patient's statement, labour pains. There was no hæmorrhage with the pains. The breasts and abdomen increased in size till the end of May, 1900, since when the breasts have got smaller, and the abdomen has remained the same size. Movements were felt in the abdomen between September, 1899, and April, 1900, when they ceased. There was no trouble with micturition or defæcation. Since the flooding in May, 1900, there was amenorrhœa. Patient's general condition, except for the flooding and pain in left iliac region, has been good all through, and she has been able to attend to her house duties.

Condition on Admission.—Abdominal Examination.—The abdomen is enlarged to the size of about eighth month of pregnancy, with a slight bulging to the right side. The tumour is well defined in outline, and feels rather firmer than the pregnant uterus. Its consistency varies, but no distinct part of a fœtus can be made out. On manipulation, the tumour is sometimes felt to get harder. Mensuration showed the greatest circumference to be just below umbilicus, and the upper border of the tumour to be nearer ensiform than pubes. There is lateral mobility. Both flanks are resonant. No fœtal heart or uterine souffle to be heard.

Vaginal Examination.—Cervix looking backwards, and the os nulliparous and hard. A rounded mass can be felt through anterior and right lateral fornices. It is firm, inelastic, and cannot be separated from abdominal tumour. To the left there is the body of the uterus into which the sound passes for three inches. The breasts were not enlarged, but showed well-developed secondary areola.

Operation, September 8th.—The abdomen was opened in the middle line, and the gestation sac found to be adherent to the anterior abdominal wall. On cutting into the sac liq. amnii and vernix caseosa came away. The wall of the sac was thin and bled a little. The fœtus, which was a full-term male, was extracted by the leg. It was not macerated, though shrunken and wasted. The funis was separated during extraction. The incision in the sac was then enlarged, and an attempt made to separate the placenta, through which there was no longer any circulation, from the interior. This failing, the sac was turned out of the abdomen as much as possible. Then all adhesions to abdominal wall and omentum were freed. It was then discovered that the sac consisted of a rudimentary horn of the uterus, joined to the healthy, full-sized uterus by a band of uterine tissue, about the size of a finger. There was no communication between the cavity of the rudimentary horn and that of the uterus. The fallopian tube was healthy, and ran along the top of the rudimentary horn. The pedicle was transfixed, firmly tied with thick silk, and divided. The edges of the cut surface of the uterus were sewn together. The wound healed by primary union, and patient made an uninterrupted recovery. R. S. R.

Obituary.

Arthur Henry Leete.

It is with extreme regret that we record the death of Arthur Henry Leete, on September 21st, 1900.

Leete entered Guy's Hospital in October, 1889. Gaining the second open scholarship. At the end of his first year he took the first prize; during his second, the degree of B.Sc., and obtained honours in the first M.B. exam. Having filled his appointments in a most able manner, he obtained in 1894 the gold medal and scholarship in medicine, and the final M.B.

In 1895 he obtained the Gurney-Hoare prize for clinical study, being the last recipient of that honour, and became M.D. with marks qualifying for the gold medal in the same year.

He was house-physician to Dr. Hale White from April to September, 1895, and at that time was elected President of the Residents. A record so brilliant marks Leete as a man of no ordinary ability. He worked well and conscientiously, and was deservedly respected and popular with his colleagues.

Those of us who only knew him later, during the last two years, found him a reserved, retiring man with a considerable brusqueness of manner when dealing with any but intimate friends.

How far his illness affected his character, one can hardly say; we think it had much to do with it. He had

a severe attack of typhoid after completing his house-physiciancy, and later discovered that he had phthisis.

I came closely into contact with him on being appointed junior ophthalmic assistant, he having held that appointment since August, 1898, becoming senior on the resignation of Dr. Eyre. I hold his memory in the highest respect, and shall always remember the many considerations which he extended to me as his junior. His ophthalmic work was always good, and he took the greatest pains to be accurate and thorough under the most trying conditions.

Acting on the advice of Dr. Hale White, he resigned the appointment in the early part of this year, as it was hoped that a sea voyage and a long rest would effect a cure, or at least retard the malady from which he was suffering, but this proved to be delusive, and he succumbed on September 21st, 1900.

One is tempted to say that Leete's career was only just starting, and that he would probably, had he lived and been able to secure better conditions, have produced much valuable scientific work. He had considerable mathematical ability, and was up to the time of his death engaged upon a book of optics which he had hoped to have finished last spring. But it was not to be, and we must bid farewell to one to whom fortune was most unkind, hiding up the worth we know was there under a certain reserved manner, probably temporary and aggravated by illness, and Time, who might have removed much that obscured his true gentleness and nobility, played him false, and snatched him from us too soon. A. W. O.

"HONOR TO WHOM HONOR."

It was certainly not the place one would have expected to hear of the late Dr. A. H. Leete. Ship Alley, a turning out of the well-known Ratcliff Highway, leads to the entrance of the Old Mahogany Bar, at one time a musical hall, well known and frequented by the maritime population of that part; but now one of the centres of the Wesleyan East End Mission.

Here it was that on Sunday, September 30th, was held a service in memory of Dr. A. H. Leete. It was here in one of the poorest and roughest parts of the East End that Leete superintended a medical mission and gave up those talents, which had enabled him to uphold the reputation of Guy's, to the poor and afflicted of this overcrowded district, refusing for their sakes many offers of worldly advancement.

There was a large gathering of all sorts and conditions, and many present remembered the kindly help of the doctor whose self-sacrificing life had been so soon taken from their midst.

Those of us who only remember Leete by his peculiar brusque and offhand manner, must feel that after all this was but a cloak to hide the deeper feelings of the TRUE MAN.

H. R.

Reviews.

The Bacteriology of Everyday Practice. By J. O. Symes, M.D., D.P.H., etc. (Medical monograph series No. 2. Ballière, Tindall & Cox, London, 1900), pp. 88. 2s. 6d. net.

Dr. Symes has had a three-fold object in writing this small work, first to point out the kind of case in which the bacteriologist can assist the practitioner; secondly, to describe the methods of identifying bacteria; and thirdly, to give directions for obtaining cultures which are to be sent to the bacteriologist. For the practitioner who qualified before the days of bacteriology, this is a most useful book; the directions for collecting material are excellent, and if they are carried out will enable the bacteriologist to give much more assistance to the practitioner than he can at present. The identification of bacteria is not so easy as one would anticipate from the perusal of this work, and it cannot be too strongly urged that the art of bacteriology can be learnt only in the laboratory, and that anyone without this training is sure to make most egregrious blunders in diagnosis.

In Lighter Vein.

A HARLEQUINADE.

(Recently performed by no one's request.)

SCENE—*Constantly Changing.*
DRAMATIS PERSONÆ—*Some People and others.*
TIME—*Two to two.*

[*Curtain rises on Colonnade. Usual groups discovered—though they don't know it*].

Enter Mr. FULL-SURGEON.

Mr. F.-S. (to H.S.): Good afternoon! Have we—hem!—anything to—hem!—do—hem!—to-day?

H.S.: Well, sir, there's a case of varicose veins.

Mr. F.-S.: Let me see—hem!—well—hem!—I think—hem!—I'll leave them for Mr. R. to see. I'm—hem!—going away for a month. (*Disappears suddenly in a cloud of hem's.*)

[*Scene changes rapidly to operating theatre.* Mr. R. *discovered removing a kidney without an anæsthetic.*]

Enter H.S.

H.S. (to Mr. R.): I believe you are doing Mr. Full-Surgeon's work, sir?

Mr. R.: Yes (eagerly). Have you anything for me to do?

H.S.: There's a case of varicose veins, sir.

Mr. R. (disappointed): Um!—well, I'm going for a holiday, and must see another case before

I go—a very remackable case—most remackable! I removed both his jaws, and now, if the man will let me, I think of removing his frontal bone. Most remackable!

H.S.: And the veins, sir?

Mr. R.: Oh, Mr. B. will be doing my work. Good day! (*Jumps down œsophageal tube.*)

[*Backcloth instantly rises on the telephone office in Colonnade.* H.S. *at telephone.*]

H.S. (*who has been there some time, and is still trying to remember he is a gentleman*): Hullo! hullo!!

Small Voice: Yes.

H.S.: Are you Mr. B.?

S.V.: Yes. Lovely weather.

H.S.: We have a case of veins, sir, and I believe you are doing our work. Shall we——?

S.V.: Oh, do what you think right, you know. Have you ever tried a hatchet? A hatchet is so obvious, isn't it? But, really, I'm on my holiday, so perhaps—oh—— Horrid weather! (*Rings off suddenly.*)

[H.S. *sees well-known form in Colonnade, and rushes up to it.*]

H.S.: We have a case of veins, sir, which hasn't been seen yet. They're all away, you know. Shall we——?

Well-known Figure (sweetly): Veins! Take 'em out, my dear. What's the boy thinking of? Take the nasty things out!

H.S. (fervently): At last!!

[*Curtain falls to Dressers' chorus*: "This is the way we wash our hands!"]

J. U. G.

Sport.

Rugby Football.

GUY'S v. KENSINGTON.

Played at Honor Oak Park on October 6th. Kensington kicked-off against the wind, and Pye-Smith returned. Some loose play then took place about the half-way, in which Kensington had the best of it. Our men, although packing well, were seen to a disadvantage in the loose. Kensington repeatedly attacked, but Guy's relieved by good kicking. Play was of a give-and-take order for some time, when McEvedey, receiving a pass from Pye-Smith, made a good run, passing several opponents, and was only prevented from scoring at the last moment. Then Kensington, by means of good passing, in which both backs and forwards took part, carried the play to half-way, and after some further passing among their backs, Bennett made a good dodgy run and scored between the posts; the try was converted. After kick-out, Guy's pressed for some time, and Kensington were forced to touch down. O'Brien received the kick-out, and taking advantage of the wind, dropped an excellent goal almost from half-way. Half-time was then called, Kensington leading by one point.

On changing ends it was generally expected that Kensington would increase their lead, but the heeling of the Guy's forwards being better than in the first half, and the three-quarters showing excellent form, we soon got into their twenty-five. Louisson, getting the ball well away from the scrum, passed to O'Brien, who, making a good opening for Morgan, enabled the latter to score; McEvedey failed in the kick. We continued to attack, and after some loose play, McEvedey secured, and making a good run, scored between the posts; the kick was charged down. Here Kensington, by good kicking and forward rushes, took the ball into our twenty-five, and eventually one of their forwards scrambled over; no goal resulted. The game was now transferred to the other end of the ground. Our backs soon began to attack. The ball being passed to O'Brien, he sent it on to McEvedey, who ran strongly and gave to O'Brien a difficult pass, which the latter secured and scored well out; the kick again failed. The whistle was blown with Guy's still pressing.

The forwards were weak in the loose but packed well, and in the second half succeeded in obtaining the ball with commendable frequency. Their taking the ball and marking on the line-out were, however, very faulty. The halves must avoid passing high, especially with a strong wind. The three-quarters, although disconcerted by the wind in the first half, handled the ball and kicked extremely well. McEvedey is a strong runner, and should be an acquisition. Harrison, in spite of the wind, caught the ball with wonderful accuracy.

Births.

CLARKE. — On September 30th, at Enville House, London Road, Leicester, the wife of Astley V. Clarke, M.D. Cantab., of a daughter.

MARSH. — On October 6th, at St. Martin's Aldington Hythe, Kent, the wife of H. Robert Marsh, M.R.C.S. Eng., L.R.C.P. of a daughter.

Marriage.

TODD-WHITE — WATERHOUSE. — On September 29th, at St. Clement Danes, by the Rev. William Manning, M.A., Vicar of St. Andrew's, Leytonstone, Arthur Thomas Todd-White, M.R.C.S. Eng., L.R.C.P. Lond., L.S.A., of Wentworth Lodge, Leytonstone, to Elsie, daughter of John W. Waterhouse, Esq., of Forest Drive, Leytonstone. "At home," October 23rd, 24th and 25th.

Deaths.

FRANCE. — On October 6th, at St. Leonards, John Frederick France, J.P. for Middlesex, F.R.C.S., F.S.A.

LEETE. — On September 21st, at Salcombe, Arthur Henry Leete, M.D., B.Sc. Lond., M.R.C.S., L.R.C.P., aged 33 years.

Ed.—S. H.

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Calendar of Coming Events.

October, 1900.

Sat. 27.—Messrs. Lucas and Lane's take-in; Drs., W. M. Robson and M. A. Collins; Cl., P. W. L. Camps.
1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C. I., Rosslyn Park, away.
II., Redhill and Reigate, away.
III., Kensington III., home.
IV., Old Alleynians III., away.
G.H.A.F.C. I., Beckenham, away.
II., Beckenham 2nd XI., home.

Mon. 29.—1.15 p.m., Clinical lecture by Mr. Lucas.
Final M.B. Lond. Exam. begins.

Wed. 31.—1.30 p.m., Clinical lecture by Dr. Perry.

November

Thur. 1.—Messrs. Golding-Bird and Dunn's take-in; Drs., J. Evans and W. S. Davies; Cl., F. W. Sime.
G.H.C.U., Address by W. Hind Smith, Esq.

Sat. 3.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.P.P.S., "An Elizabethan Handbook of Therapeutics," by H. L. Eason.
G.H.R.F.C., I., Wickham Park, home.
II., R.N.C. Old Boys, away.
III., St. Paul's School II., away.
IV., Wasps, III., away.
G.H.A.F.C. II., S.C.C., home.

Mon. 5.—1.15 p.m., Clinical lecture by Mr. Lucas.

Wed. 7.—1.30 p.m., Clinical lecture by Dr. Horrocks.
G.H.R.F.C. I., Royal Engineers, away.

Thur. 8.—Messrs. Jacobson and Fripp's take-in; Drs., D. H. Trail and A. C. H. Gray; Cl., M. D. Wood.
G.H.C.U.—Students' Meeting.
Probable date of Primary Fellowship Exam.

Fri. 9.—L.D.S. Eng. Exam.

Sat. 10.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., II., Beckenham, home.
III., Richmond St. Mary's, away.
IV., Catford Bridge, III., away.
G.H.A.F.C. I., Eastbourne, away.
II., Woodford Albion, home.

Guy's Hospital Gazette,

OCTOBER 27, 1900.

Some Points in connection with Pleuritic Effusions.

CLINICAL LECTURE BY Dr. FAWCETT.
July 11th, 1900.

Gentlemen,—There have been three cases of effusion into the pleura in Clinical ward during the last week. Two of them were purulent and one a simple effusion. As they instance extremely well some of the points in causation, diagnosis, and treatment of these conditions, I thought it would be of interest to take all three of them for our lecture.

I will first of all read you the notes of the cases made for me by Mr. T. P. Thomas.

Case 1.—H. P., æt. 40, was admitted into John on July 4th. There are no points of interest in the previous history.

The history of his illness is as follows:—That he was quite well till a year ago when he was ill for three months with what he calls "rheumatism." During these three months he was in bed. The illness began with severe pain in the upper part of the left side of the thorax, and he also had stabbing pain over the left base and across the upper part of the abdomen to the right side.

At the end of this time he got better and was fairly well till fourteen days ago, when he says he was again taken ill with "rheumatism" and had some difficulty in breathing.

Condition on admission.—Temperature 97°, pulse 60, respiration 18. He was well nourished, of ruddy complexion, and healthy looking.

Respiratory system.—He has no dyspnœa nor pain when lying in bed. His breath is of an extremely *unpleasant odour*. He has some cough but cannot be made to expectorate anything and apparently he swallows it all. The left side of the chest moves very little. It is much flattened over the upper spaces anteriorly, and below this the whole side looks smaller than the right. The cyrtometer tracing taken at the

level of the nipple shows the retraction of the left side very well.

The deficiency of movement is confirmed on palpation and T.V.F. is completely absent in lower half of axilla and over the lower half of the chest posteriorly.

Over the first two spaces anteriorly the resonance is impaired and of a high-pitched or tympanitic character. Between it and the commencement of the cardiac dulness the note is a better one. In the axilla and over the lower half of the chest behind the note is dull, but in the latter position is even more "board-like" than that in the axilla. Over the right side the note is somewhat hyper-resonant.

Breath-sounds are diminished in intensity, with prolongation of expiration, as far as the second space. Over the apex behind, and as far as half way down the thorax, a vesicular murmur can be heard, but it is very faint, is "bronchial" above, but in the lower half and in axilla no entry at all could be detected. The voice-sounds are also diminished above and completely absent in axilla and over the lower half of thorax behind. No adventitious sounds were heard anywhere. On the right side the breathing was compensatory in character.

Circulatory system.—Colour good. No cyanosis. No clubbing of fingers. Cardiac impulse was in the fourth space, three-quarters of an inch internal to nipple. Cardiac dulness began at the level of the third rib above, and extended towards the right as far as the left border of the sternum.

All the other systems were normal. His temperature was subnormal, and remained so during the three days he was under observation previous to operation.

The diagnosis of this case presented several very interesting features, and it is for that reason that I have detailed carefully the physical signs which were present. The case was evidently a long standing one. The patient had been ill, more or less, for twelve months with symptoms of some pulmonary disease. This was clear, not only from the history, but from the signs found on examination. The conditions we discussed to account for the physical signs were:—(1) Fibroid lung, with thickened adherent pleura. (2) Fibroid phthisis. (3) Fibroid lung, with bronchiectasis and gangrene. (4) Malignant tumour. (5) Localised empyema.

1. In favour of this was the unilateral character of the lesion, the immobility and retraction of the left side, the flattening above, and the impaired and dull note on percussion. All these are signs commonly met with in fibroid lung. There was, however, little displacement of the heart, no pulling of it over to the left side, nor any increase of area over which the cardiac impulse could be seen or felt. No adventitious sounds were to be heard.

2. As to phthisis, the symptoms were so completely one-sided that we thought it was probably not due to this, and there were no adventitious sounds whatever to be heard. Still it is possible that the condition of the lung beneath was tubercular, and an old phthisis at the apex would account very well for the physical signs there. We know also that empyema due to infection by pneumococci or streptococci may occur in a tuberculous subject. We have, however, been unable to get any sputum for examination and so decide this point for certain.

3. As regards 3, the foul odour of the breath suggested this, and also to some extent the physical signs. Our physical signs were, however, as we have heard, chiefly negative ones, *i.e.* absence of the ordinary respiratory signs, and not the positive signs of consolidation or cavitation such as we should have had with bronchiectasis and gangrene. The general condition of the patient was, too, against any such serious lesion.

4. Malignant intrathoracic tumour. — We considered this only to dismiss it, at any rate, at the start. In cases of malignant disease of the lung the signs may be very like those of a pleuritic effusion. There may be no displacement of viscera, no enlargement of the affected side, no signs of pressure upon intrathoracic structures producing distension of superficial veins, etc., and I dare say we have most of us seen cases sent into the wards from the Out-Patient department in which the diagnosis of pleuritic effusion has been made, but where puncture has not supported the diagnosis, and where the case turned out to be one of malignant disease.

Possibly some of you may remember a young man who was in Stephen under Dr. Perry some six months ago. He was in more recently under Dr. Pitt He had all the signs of pleurisy with effusion, but an exploratory puncture performed several times was negative, only blood being withdrawn, and ultimately the diagnosis of malignant disease of the lung was arrived at.

You have to remember, however, that in these cases, what we commonly designate signs of pleuritic effusion are not so at all. They are mostly the absence of the normal respiratory

sounds, and it is not till we have displacement of viscera, and the results of puncture, that we possess positive evidence of its presence.

5. The last cause was the one we favoured the most, and for the following reasons:—

(i.) The absolute dulness over the lower half of the back of lung and in the axilla, and the complete absence of breath-sounds and voice-sounds over these areas.

(ii.) The absence of any adventitious sounds.

(iii.) Although the chest was retracted yet the heart was *not* pulled over to the left. It was somewhat displaced upwards, but this was no doubt due to the shrinking of the upper lobe from a chronic process which had previously occurred there.

An exploratory puncture was made below and external to the angle of the scapula and pus obtained. The next day the abscess was opened by Mr. Dunn, a piece of rib being also removed.

I have made no reference to the temperature because in chronic cases no distinction is possible by this means.

The temperature was subnormal in this patient while under observation. The case is also interesting as showing you that although fluid is present yet the chest wall may be retracted. That may be the case even with an acute pleuritic effusion.

Having come to the conclusion that the case was possibly one of a localized empyema, how did we explain the apical flattening, the retraction, and the foul odour of the breath? Well, if you recall the history of the case you will remember the man had been taken suddenly ill some twelve months ago, with probably an acute pulmonary disease. He had been perfectly well up to that time. We thought that the affection had most likely been either an acute pneumonia or a pleurisy, and that either the lung had not expanded after the collapse produced by the effusion, or that it had not completely resolved after the pneumonia, and as a result we had a condition of thickened and adherent pleura with "fibroid lung" produced.

The foul odour of the breath might have been due either to—(1) The empyema having opened through the lung and formed a small sinus track by means of which it was being imperfectly emptied, or (2) To infection of the air in the air passages from the pleura, without any direct connection between them.

This latter may happen, just as in an abdominal abscess the contents may become foul-smelling from infection through the gut wall, although there be no opening between the gut and abscess.

Difficulties in finding pus.—Although we were fortunate in finding the pus in this case, you have to remember that in many cases, even though pus be present, you cannot find it, and I want to impress upon you the fact that, just because you cannot find it, it does not mean it is not there.

At the operation performed by Mr. Dunn a needle was inserted a space lower and further forward, with the object of draining the cavity better. No pus, however, was obtained, although it was almost, if not quite, as dull at this spot. To find the cavity Mr. Dunn had to explore further back.

Puncture may fail in—

(1) Small chronic empyemata, especially if they are situated in the posterior mediastinum or on the diaphragm.

(2) Pus may be very thick, and will not run through needle.

(3) Pus may be withdrawn from a dilated bronchial tube. It is generally, in these cases, not in the same quantity one obtains from an empyema.

(4) From the syringe being faulty, or from it not being properly inserted.

Ætiology.—In this case the report we received from our bacteriologist, Mr. Pakes, was that pneumococci were present. So you see these bacteria may be present in an abscess that has probably existed for twelve months.

The other organisms which we commonly find in empyæmata are streptococci and staphylococci; tubercle bacilli are rarely found.

In children the pneumococcus is the commonest cause. It was present in Case 2, the child I shall tell you about later.

It is of course quite possible that there was no preceding pneumonia, for the diplococcus may produce an empyema as the primary lesion just as it may produce a meningitis.

If it is secondary to a bronchopneumonia, then there is generally an interval before the evidence of an empyema becomes clear.

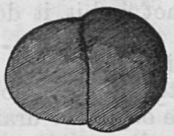
Before dealing with the general course and symptoms I will read to you short abstracts of the other two cases, as they serve to bring some of the points before us.

Case 2.—F. R., æt. 3½ years, admitted July 6th. She began to be ill six weeks ago, with pain in the side and abdomen. She was attended by Dr. Vick, of Plumstead, and he diagnosed pneumonia.

Condition on admission.—Temperature 97°, pulse 114, respiration 26. The patient is a pale

sallow-looking child. She is not much distressed. There is slight clubbing of the fingers.

The left side of the thorax was markedly prominent, and the antero-posterior diameter increased. The condition was well shown in cyrtometer tracing, but unfortunately it was lost. It, however, was something like this—



The greater bulging was over the second, third, fourth and fifth costo-chondral junctions. The outlines of ribs were obscured and the intercostal spaces bulged. All the other signs associated with pleuritic effusion were present, including displacement of the heart to the right side. The temperature was subnormal.

Case 3.—C. R., female, æt. 48. Admitted July 4th. Nine days previously she noticed pain between her shoulders and on the right side. For the last four days she has been short of breath. She was very dyspnœic and restless. She, however, did not think there was "anything much the matter with her." The usual signs of a pleuritic effusion occupying the large part of the right pleural cavity were present, with compensatory breathing on the left side and displacement of the heart to an inch and a half outside the nipple, and of the liver edge one inch below costal margin. The other systems were normal. The temperature was slightly raised, reaching on the day after aspiration 101°.

With regard to treatment, Case 2 was first aspirated, as the chest was so full, and then opened the next day, and Case 3 was aspirated at once and 70 ounces of clear fluid withdrawn.

Onset.—The commencement may be very insidious. It may be altogether latent. More commonly, however, it is marked by some pain, with fever and cough and dyspnœa. In Case 2 the child was thought to have had pneumonia at first. In Case 3 the onset, apparently, was not a very acute one, some pain in the back and right side being the most marked symptoms, and after that a gradually increasing dyspnœa.

Fever.—In Case 2 there was no fever, although there was pus, and in Case 3, although a simple effusion there was a little rise of temperature, and that is commonly the case. Fever is, however, present in most cases, but in chronic cases, as I told you before, no distinction can be made by means of the temperature chart. If pus be present and it be foul, there is generally a hectic temperature, but it was not so in Case 1. You see, therefore, even from these three cases, how little reliance can be placed upon the temperature.

Pain is also a very variable symptom. It may be the chief sign of pleurisy. It may be slight, or there may be none at all. We saw that in Cases 1 and 2 pain was not present, and in Case 3 it was the only symptom complained of, and then was slight. The pain in the latter case was chiefly felt in the back. The side is the part most often affected, but it may be felt only in parts at a distance, such as the abdomen.

Dyspnœa was only marked in Case 3. It may at first be due merely to difficulty in breathing freely on account of the pain. Later it is due to the effusion, but after a time patients may become accustomed to the diminution in their breathing space so that the dyspnœa is less marked than at first.

Cough.—Generally present. It was so in Cases 1 and 3, but not in the case of the child, and that is the common event.

We see, then, that on going through the signs usually associated with the disease, how very variable they are, and the cases I have related to you instance these facts well.

The physical signs of the disease I have drawn your attention to already.

The diagnosis, however, between pus and serum is important. Difficult as it is to determine sometimes, yet there are some points which help us.

Fever, I have told you, cannot be relied on.

Clubbed fingers and a sallow complexion are often seen with pus. It was so in the child, Case 2.

In children effusion is commonly purulent.

If rigors and anæmia with sweating are present.

After pneumonia.

In septic diseases, and after acute specific fevers;

If œdema or redness of chest wall be present and dilatation of the superficial veins; or

If there be a sudden expectoration of pus or a pneumothorax develope; then pus is generally found.

Different kinds of pleural effusion.—

1. Serous.—In the acute cases it is a diluted plasma with a specific gravity of 1008-1024. In cases of hydrothorax, that is of passive effusion, such as in association with the dropsy of Bright's disease, it may be only 1006-1008. The proteids are, of course, those of the plasma, viz., serum

albumen, fibrinogen and paraglobulin. The fluid is generally clear, but may be, more or less, milky, either from admixture with leucocytes or molecular particles and rarely from the rupture of the thoracic duct. The proteids generally coagulate after withdrawal, and in case 3 it is stated in the report "that a firm clot was found soon after withdrawal."

2. Pus.—If present it has generally been so all along. Of course a serous effusion might become purulent after operation, but an effusion at first serous, and later purulent, is possible, though rare.

3. Blood or blood-stained fluid.—Not by any means met with only in malignant disease.

(i.) There may be some in cases of simple effusion, either from rupture of new vessels in the lymph deposited, or from the skin puncture.

(ii.) In the passive effusion from heart disease the fluid is sometimes blood stained.

(iii.) In malignant or tubercular disease of the pleura.

(iv.) In "bleeders."

Results of—

1. Adhesions may form after the effusion has been absorbed. They give rise to no signs unless associated with some retraction of the chest wall.

2. Absorption.—The physical signs gradually become less marked, and a rub may ultimately reappear, or absorption may recur rapidly all over the chest. It is sometimes very difficult to say when the effusion has disappeared, for the lung does not expand again, and often more or less dulness and deficient entry of air may remain. The lung may become fibroid and the layers of pleura firmly adherent.

3. Empyema.—If not incised it may terminate by—

(i.) Rupture through the lung, a small opening being made between the lung and a bronchus, or else through the lung substance. The expectoration then often becomes fœtid. The empyema may be cured in this way, or it may lead to sudden death by the air passages rapidly becoming filled with pus and choking the patient. In other cases, however, the discharge may persist for a long period, and the patient ultimately die of exhaustion from a gradual poisoning by products absorbed, or by infection of neighbouring portions of lung, and so a general septic broncho-pneumonia.

(ii.) Rupture externally.—The common situation is in the fifth space in the nipple line. It has all the appearance of a superficial abscess. The results of this method of getting rid of the pus are extremely unsatisfactory. The opening is generally insufficient, and the patient ultimately may die from lardaceous disease of the viscera.

(iii.) Rupture sometimes occurs into other parts, as the pericardium, the peritoneum, or into the œsophagus.

(iv.) Sometimes the empyæma cavity is prevented from closing by the lung beneath not having expanded again. The lung, for example, after a pneumonia, does not resolve properly and becomes "fibroid," or it may be tightly bound down by a thickened and adherent pleura. Or the tissues in the neighbourhood of the incision may become infected—a spreading cellulitis follows, or the ribs themselves undergo necrosis.

(v.) Deformity almost always ensues, to a greater or less extent, on the affected side. As a result the viscera in thorax and abdomen become displaced laterally and upwards, and ultimately the right side of the heart may become dilated.

Prognosis. — The prognosis depends on the amount and character of fluid present, the cause of the pleurisy and the results which ensue from it.

(i.) If the fluid be large in amount the possibility of sudden death must always be remembered. A patient may be seen with a chest full of fluid but yet whose pulse is regular and of good tension, and who is also breathing quietly. There appears to be no urgency about the removal of the fluid. Yet suddenly, and often after some little exertion, the patient becomes of a pale dusky colour, is cold and clammy, the pulse becomes weaker and weaker, and he is soon dead. Another cause of sudden death is, as I have mentioned already, the choking produced by a sudden rupture into the air passages. In the former case the sudden death may be due to pulmonary thrombosis, a clot having formed in the right side of the heart and spread to the pulmonary artery or to an embolus separated from the thrombus. Sometimes at the autopsy nothing can be found to account for death, and it has been suggested that the large vessels at the base of the heart may have been twisted over or kinked. After paracentesis, death may rapidly ensue from an acute œdema of the lungs supervening on the sudden release of the fluid. This condition is associated with severe dyspnœa and obstruction to the circulation, with profuse frothy expectoration.

(ii.) The patient may succumb to the primary disease, such as tubercle, Bright's disease, or

some septic source to which an empyema owes its origin.

(iii.) The results which may ensue, and their importance, have already been dealt with in discussing the results of the effusion.

Treatment.

(i.) In recent small serous effusions it is not only unnecessary, but wrong, to remove the fluid at once. The fluid effused is merely the result of the inflammatory process. If it be removed at once fluid is again immediately poured out as the subjacent inflammatory condition still persists. The fluid in these cases acts as nature's preventive to a further effusion taking place.

Other means should be adopted to aid the absorption of the fluid, viz., counter irritation of the chest by painting with Liq. Iodi Fort. and Tinct. Iodi, or the application of a blister and the administration of such drugs as Potassium Iodide internally.

It is also wise to give the patient a brisk purge, Calomel gr. iii. to v. to start with, and a diaphoretic and diuretic internally so as to aid the elimination of the fluid by all possible paths, *e.g.*—

Pot. Cit., gr. xx.
Spt. Ætheris Nit., ʒss.
Liq. Ammon. Acet., ʒss.
Aq. Chlorof., ad ʒj 4tis horis.

If these be associated with bronchitis, then add some Vin. Ipecac., or if with acute rheumatism Salicylate of Soda, and so on with other complications.

Later in the course of the disease stronger diuretics may be given, such as the Pil. Diuretica, or some combination of Digitalis and Squill.

(ii.) Conditions which determine the performance of paracentesis—

1. With dulness over a large extent of the affected side.

2. Urgent dyspnœa, with cough, cyanosis, much frothy expectoration or sweating.

3. A further increase, after previous arrest or decline.

4. If the effusion persist for longer than fourteen days.

5. If opposite lung be affected with bronchitis, pneumonia, pleurisy, or if the heart or its surrounding structures being previously diseased, the pleuritic effusion leads to still further obstruction to the heart's action.

A single paracentesis generally cures the patient, the fluid left being soon absorbed.

(iii.) In empyema the thorax should be opened as soon as possible.

a. If the quantity be not very great, an incision should be made at once; and if a large enough opening cannot be obtained by it alone for proper drainage, or if the discharge be foul, then a piece of rib must be resected. This latter proceeding was rendered necessary in both Cases 1 and 2. In the former the ribs were so crowded together and the pleura so thick that it was impossible to do without it.

b. If the empyema be a very large one, as in Case 2 of the child, it is best to remove some of the pus first by paracentesis. Mr. Dunn recommended that this should be done for the reason that a sudden evacuation of a large quantity of pus may cause a considerable shock. This is lessened by a previous aspiration. The further treatment of empyema is chiefly surgical: the question of removing more than one rib, the gradual removal of the tube, and so on. If the sinus, however, does not seem inclined to close, it is important not to wait too long, *e.g.*, more than two or three months before advising a further resection.

As paracentesis is so often left in the hands of the physician, it is most important that you should all be thoroughly well acquainted with the details of the operation.

It must be performed with absolutely *strict* antiseptic precautions. The aspirator is, on the whole, preferable to a trocar and cannula, as by this means small pieces of lymph may be removed, and so blockage of the tube prevented.

The tap connected with bottle should be turned on *slowly*, and only sufficient vacuum made to allow of a steady, gentle flow through the cannula. If the fluid be drawn off too quickly the patient will begin to cough, and so you may be obliged to stop any further withdrawal of the fluid.

You should draw off as much fluid as you can without causing too much discomfort to the patient; but if the patient complain of increasing pain in the chest, if the fluid becomes bloody, or if the patient begin to expectorate a frothy fluid, then aspiration must be stopped.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Taylor.

Mary	38.	Peritonitis. Pleurisy. Tuberculous.
	39.	Rheumatism. Endocarditis.
	40.	Enteric fever.
	41.	Dyspepsia.
	42.	Gastric ulcer. Thrombosis of femoral veins.
	43.	Hemiplegia. Mitral stenosis.
	44.	Chorea.
	45.	Tubercular kidney. Excised.
	46.	Enteric.
	48.	Exophthalmic goître.
	49.	Broncho-pneumonia.
	50.	Gastric ulcer.
Cot	56.	Marasmus.
	57.	Broncho-pneumonia.
Philip	21.	Acute rheumatism. Pericarditis.
	23.	Right hemiplegia. Aphasia.
	24.	Diabetes mellitus.
	25.	Appendicitis.
	26.	? Enteric fever.
	27.	Aortic regurgitation. Abdominal aneurysm.
	28.	? Cerebral abscess.
	29.	Mitral stenosis and regurgitation.
	30.	Mitral stenosis and regurgitation.
	31.	Left hemiplegia.
	33.	Enteritis.
	34.	Ascites.
	35.	Pneumonia.
	37.	Morbus cordis.
	38.	Enteric fever.
	39.	Appendicitis.
	40.	Morphomania.

Cases under Dr. Fawcett (for Dr. Hale White).

Mary	13.	Cerebral tumour. Optic neuritis.
	14.	Acute osteo-arthritis.
	15.	Chorea.
	17.	Mitral stenosis.
	19.	Gastric ulcer.
	21.	Mercurial poisoning.
	23.	Hemiplegia. Cerebral thrombosis.
	24.	Pleurisy with effusion. Paracentesis.
Cot	54.	? Pneumonia.
Philip	1.	Acute nephritis.
	2.	Appendicitis.
	3.	Dropsy. Chronic nephritis. Heart disease.
	4.	Aortic aneurysm.
	5.	Enteric fever.
	6.	Diabetes.
Philip	8.	Enlarged liver and spleen. Pyrexia.
	9.	Acute rheumatism.
	10.	Tubal nephritis.
	11.	Appendicitis. Operation.
	12.	Spastic paraplegia.
	13.	Carcinoma hepatis. ? Secondary.
	14.	Malaria. Irregular fever.
	15.	Enteric fever.
	17.	Eczema.
	19.	? Carcinoma of stomach.
	20.	Phthisis. Tubercular laryngitis.

Cases under Dr. Perry.

Mary	2.	Pericarditis. Mitral stenosis. Right pleurisy with effusion.
	3.	Gastric ulcer.
	4.	Rheumatism. Mitral stenosis.
	5.	Typhoid fever.
	6.	Ascites. ? Malignant.
	7.	Rheumatism. Mitral disease. Pericarditis.
	8.	Typhoid fever.
	9.	Eczema.
	10.	Ascites following ? congenital heart lesion.
	11.	Rheumatism. Mitral incompetence.
	12.	Peripheral neuritis. Alcoholic.
Stephen	2.	Renal calculus. Operation. Thrombosis of veins of leg.
	3,	Abdominal tumour. ? Splenomegaly.
	4.	Appendicitis.
	5.	Tuberculous peritonitis.
	6.	Acute rheumatism.
	7.	Broncho-pneumonia.
	8.	Influenzal pneumonia.
	9.	Typhoid fever.
	10.	Chorea.
	11.	Fibroid phthisis.
	12.	Sarcoma of lung.
	13.	Sarcoma of tonsil. Tracheotomy.
	14.	Typhoid fever.
	15.	Rheumatism. Double aortic and mitral disease.
	16.	Rheumatism. Double mitral disease.
	17.	? Septicæmia.
	18.	Acute rheumatism.

Cases under Dr. Bryant.

Mary	25.	Enterica.
	26.	Purpura.
	27.	Paresis and anæsthesia of both legs.
	28.	Dyspnœa with abductor paralysis. Tracheotomy.
	29.	Pyuria.
	30.	Intestinal obstruction.
	31.	Pleurisy with effusion.
	32.	Gastric ulcer.
	33.	Typhoid with hæmorrhage.

Mary	34.	Right hemiplegia. Aphasia. Cerebral embolism. Mitral stenosis.
	36.	Chronic effusion, right pleura and peritoneum. Old pericarditis.
Stephen	21.	Ague.
	22.	Pericarditis with effusion.
	24.	Enterica.
	25.	Enlarged liver and spleen. ? Origin.
	26.	Aortic incompetence.
	27.	Ascites with thrombosis of internal saphenous vein.
	28.	Leuchæmia.
	29.	Rheumatism. Endocarditis.
	31.	Alcoholic neuritis and phthisis.
	32.	Enterica.
	33.	Enterica.
	34.	Carcinoma of stomach.
	35.	? Gallstones. ? Growth.
	36.	Pleurisy with pericarditis. Hæmaturia.
	37.	Aneurysm of 1st part of aorta.
	38.	Cerebellar tumour.

In the Surgical Wards.

Cases under Mr. Howse.

Astley-Cooper	5.	Fracture dislocation of spine at 7th dorsal vertebra.
	6.	Fractured base.
	16.	Compound fracture of tibia and fibula.
Job	4.	Syphilitic necrosis of skull.
	10.	Stricture of urethra.
	23.	Erythema nodosum.
	24.	Epitheliomatous glands in neck.
Lydia	6.	Epithelioma of tongue.
	13.	Caries of rib.
	Cot A.	Hare lip and cleft palate.

Cases under Mr. Lucas.

Astley-Cooper.	Cot.	Fractured femur.
Lazarus	8.	Varicose veins. Ichthyosis.
	16.	Perineal sinus.
	20.	Inguinal hernia.
Martha.	4.	Tubercular disease of wrist.
	8.	Intra-capsular fracture of neck of femur.
	9.	Recurrent carcinomatous glands of axilla.
	12.	Rodent ulcer.

Cases under Mr. Golding-Bird.

Luke	5.	Appendicitis, retained testis and double inguinal hernia.
	7.	? Vesical calculus.
	13.	Psoas and lumbar abscesses.
	14.	Recurrent sarcoma of superior maxilla.
Charity	6.	Recurrent tubercular disease after Syme's amputation.
	17.	Osteo-arthritis.
	Cot D.	Dermoid cyst.

Cases under Mr. Jacobson.

Astley-Cooper	7.	Compound fracture of tibia and fibula. Fractured shaft of femur. Fractured shaft of humerus. Fractured radius and ulna. Scalp wound.
Cornelius	4.	Concussion. Contusion of brain.
Naaman	2.	? Hygroma of neck. ? Deep lipoma.
	3.	Epithelioma of tongue.
	7.	? Torsion of cord. ? Cellulitis of scrotum.
	12.	Ectopian Vesicæ. Hypospadias.
Dorcas	5.	Carcinoma mammæ.
	8.	Old necrosis of femur.
Clin. Priv. Room.		Biliary calculus.

Cases under Mr. Symonds.

Job	9.	Pyloric stenosis
	19.	Periostitis of tarsus.
Lydia	19.	Retained testis.
	20.	Sarcoma of tonsil.
Patience	2.	Varicose and syphilitic ulceration of leg.

Cases under Mr. Lane.

Lazarus	14.	Peri-nephritic abscess. ? Sarcoma.
Martha	4.	Tubercular wrist.
	12.	Old Pott's fracture.

Cases under Mr. Dunn.

Luke	1.	Ulnar paralysis. Fractured humerus.
Charity	22.	Carcinoma mammæ.
	Cot D.	Dermoid cyst.
Samaritan	12.	Septic dermatitis.

Cases under Mr. Fripp.

Naaman	20.	? Tubercular abscess in neck.
	22.	Chronic hydrocele.
Dorcas	21.	Epithelioma of rectum.
	22.	Femoral hernia.
Samaritan	7.	Cellulitis of leg.

Pass List.

University of Cambridge, October, 1900.

EXAMINATION IN SANITARY SCIENCE.

W. A. Densham.

Second Conjoint Examination, October, 1900.

R. G. Anderson, F. Barnes, H. B. German, G. F. Hardy, F. C. R. M. Knight, J. F. Rey, D. H. Richards.

First Conjoint Examination, October, 1900.

Chemistry and Physics.—A. M. Benett, W. H. S. Burney, E. L. R. Norton, E. White, H. D. Wyatt.

Practical Pharmacy.—H. Bacon, T. R. Beale-Browne, E. Shelton-Jones, R. M. Wingent.

Elementary Biology.—S. K. Poole.

With the Army Medical Corps in South Africa.

(By Our Special Correspondent.)

(Published by permission of the Director-General of the Army Medical Service.)

Wolvehock, O.R.C.,
August 17th, 1900.

One sees but little war-medicine or war-surgery now on the lines of communication; but a stray bullet every now and again finds its mark on one of our soldiers. Three hundred men of the 8th M.I. were reconnoitring the other day to the east of this station, when one of their scouts found himself suddenly face to face with a Boer on foot, who pointed his rifle point blank at the scout's abdomen. The scout knocked the barrel aside, but the rifle was fired and the bullet passed through the flesh of the thigh at a few inches' range. The powder was, of course, blown into the skin all round the site of injury, and after three days the wounds were filled with a black slough, and there was considerable tenderness, with pains shooting up and down the limb. The wound had been thoroughly washed and dressed at the time; but probably nothing could have prevented the occurrence of inflammation under the circumstances. The case will probably do well now that it has been sent into comfortable quarters, in No. 3, at Kroonstad.

The *transfer of sick and wounded* is now carried on most systematically, and without interruption. There are three hospital trains constantly passing this station to and from Pretoria. North of the Vaal sick are evacuated into No. 2 (formerly at Wynberg), or the Irish or Langman's hospitals in Pretoria, No. 6 at Johannesburg, and various smaller hospitals; while on this side of the Vaal, except for a small hospital of thirty beds at Viljoen's Drift, all are sent down to No. 3 at Kroonstad, or beyond. Here there is still a house which is used for slight cases, likely to be well in a few days—cases of poisoned limbs, tonsillitis, or diarrhœa, requiring careful dieting, which the private soldier by himself is incapable of carrying out. But the P.M.O. of lines of communication between Kroonstad and Pretoria naturally does not want small irregular hospitals to accumulate along the railway; and, now that there is good sick transport, cases are easily transferred in an early stage, before there is any danger of perforation, to a comfortable hospital. The three excellent R.A.M.C. orderlies formerly stationed here have now been sent to the small hospital at Viljoen's Drift, and such work as is necessary is carried out by two men from the regiment, one of whom has had some medical training. In case of action, if the line were cut on both sides, the wounded would have to be treated as well as possible here, and even so they would not do badly; but probably the railway would be open on one side, and they could be quickly sent either up or down the line.

A fresh medical officer has been sent to Taaebosch, ten miles north of here, so that the writer has now only two stations in his charge. This involves a twenty-mile ride on three days a week, while on the other four, except for an hour's work in the morning, a certain amount of correspondence, and a few odd medical and sanitary jobs, there is no work to be done. It is a lazy life, but the time is easily filled in by reading, sleeping, and playing Bridge, and by talking to officers travelling up and down the line. The trains usually stop here for some time, and not a few will now be changing here for Heilbron, which was reoccupied on Tuesday for the twelfth time by Hunter's column.

Dr. George Turner, formerly the popular representative of Public Health at Guy's, and for the last five years chief medical officer of health to the Cape Government, passed here the other day on his way to Pretoria. He has given up his work at the Cape for an important sanitary post at head quarters in Pretoria; and it is satisfactory, not only to the Guy's school but also to the nation, that the services of so eminent an authority should have been obtained to try and prevent if possible another outbreak of illness amongst the troops after the approaching rainy season. It will be remembered that Dr. Turner was to a large extent responsible for the extermination of the rinderpest, the greatest enemy of South African farmers; and it is to be hoped that his invaluable services which have as yet received but scanty recognition from the Cape public will be more fully recognised in the Transvaal.

This question, of the prevention of disease through *contamination of the water supply* during the coming rains, is one of immense and pressing importance. From the neighbourhood of Johannesburg right down to Kroonstad the troops draw their drinking water either from wells or dams close to the line of march. The soil along the whole of this route must be considered as infected by the carcasses and refuse which have been strewn about on the veldt, especially in the neighbourhood of the dams. When the rains come down in torrents, as they may be expected to do in a month's time, the surface water running down into the dams and into some of the wells will contaminate them; the germ-spores, now latent, will become active, and serious epidemic may again break out in every camp. It is to be hoped that orders will shortly be issued for every camp to make entirely new arrangements for its water-supply. Water is obtainable in many places at a few feet, here, for instance, at seven feet below the surface. If pumps can be provided for keeping the workings dry, wells should be sunk near every camp; and if not, dams should be dug at some distance from the line of march so as to collect the water running down from a clean slope of veldt. A dam measuring 70,000 cubic feet, or an average of 100 feet by 10 by 7, would hold, roughly speaking, 40,000 gallons, or enough, after allowing for evaporation, to give every man in a garrison of 300 half a gallon a day for 6 months. The garrison would do their own digging; and some central sanitary authority should superintend the work

all along the line. Such dams and wells, if surrounded by barbed wire, should remain free from surface water and direct contamination. But it is to be hoped that, if these camps are likely to be maintained, as some are bound to be, some consistent scheme may be promptly put into effect.

A colleague passing through here on Monday described three interesting cases of *exophthalmic goitre* following wounds. The symptoms were typical, and did not abate as the wound healed. They followed close on the occurrence of the wounds, and the wounds were of various kinds, but in no way related to the symptoms, one for, instance being a scalp wound, and another a wound in a limb. One subject was certainly of a nervous temperament; but another was equally stout-hearted, even under fire. The cause, however, appears to have been nervous shock.

The student of *mental diseases* finds a good deal of interest in military medicine. The nervous relaxation of the sphincters under fire is a commonplace of this as of all wars, and officers who have taken part in any of the disastrous incidents of the campaign will give abundant evidence on the subject. In an early letter of this series a case of apparent general paralysis was described, in which the patient developed the most alarming symptoms in a very short space of time after he had been sent down from the front. More common are cases of melancholia; and the writer has to regret the loss of an old school-friend, an officer who, after performing the most responsible duties in General Buller's relief column, developed acute melancholy and shot himself on the way home. He had only been married a month before being ordered out to the war.

The writer went out with a party of mounted troops, with a small escort of infantry and one gun, to *burn the house* of a prominent Boer six miles north-west from here in return for the break in the line near this station ten days ago. This particular farm was selected as belonging to Hans van der Merwe, a most prominent anti-Britisher in these parts; and a copy of Lord Roberts' proclamation on the subject, in Dutch and English, was sent out to the old wife in the early morning by native runner, giving her till ten o'clock to clear out the furniture and belongings from the house. The troops arrived on the scene by ten to find all the seven grandchildren, from one to sixteen, busy in carrying out their goods and laying them to windward of the house—beds and chairs and tables, biltong drying on sticks, probably for the Boers on commando, canary-birds, a few pictures and the huge-clasped family Bible, presented to "Petrus Paul van der Merwe, geboren 1865," old Hans' son. The house was of stone and brick, with an iron roof, and looked as if it would not burn; but a good bundle of dry hay and an old door were laid in the room to windward, a match was applied by the Colonel, and in a minute there was a blaze from every window, and a column of smoke visible for ten miles in every direction. The poor people set up a most dismal howl on seeing the house on fire; but every eye seemed dry, and as it was only ten minutes' walk to several farms belonging to their relations, and the damage could soon be repaired when my lord returns from the wars, it is possible that the grief was not altogether genuine. However, it is poor kind of work, and the force was very glad to mount horse and return.

F. E. FREMANTLE.

Alginoid Iron.

The very latest "new drug" used at Guy's is Alginoid Iron. It is a pleasure to have to record that it is of British origin. Most of these new remedies are made in Germany; they are synthetic compounds, and come in so full a stream that one is lost in conjecture as to what the future of this supply will be. If the introduction of Kairin in 1882 be taken as the beginning of the era of modern synthetic medication, we find that up to 1896 these products numbered 800, and these have been increased during the last three years by a further addition of 1200. Alginoid Iron or Ferric Alginate is a compound of iron with alginic acid—an acid obtained from sea-weed. It is a strong acid, evolving CO_2 from alkaline carbonates in the cold. The soluble alginates are those of the alkaline metals and of magnesium. The insoluble salts are of the other alkaline earths, and of the heavy metals. Alginoid Iron is prepared by decomposing Ferric Chloride with Sodium Alginate. A gelatinous, brown precipitate is obtained, which, upon drying, forms a tasteless, insoluble brown powder containing 10·97 per cent. of iron. It is soluble in ammonia. Therapeutic authorities state that whatever form of iron be given by the mouth it is converted in the stomach into ferric chloride, with probably a little ferrous chloride. This statement must now be modified, for Alginoid Iron passes through the stomach unchanged, and is not acted upon by the gastric juice. When it reaches the alkaline part of the alimentary canal it is dissolved.

Alginoid Iron has been administered with marked success in cases of anæmia and chlorosis, and even when gastric ulceration is present it is well borne, and shows a sedative action by arresting vomiting. It can be employed, therefore, when other preparations of iron would not be tolerated. It has no astringent effect upon the bowels, and does not produce constipation; on the contrary, the effects are slightly laxative. The dose is from 2 to 15 grains. It is administered in the form of powder, in cachets, or as a pill. It may also be given in solution by taking advantage of its solubility in ammonia.

The following makes a good mixture—

℞ Ferri Alginat., gr. v.
Spt. Ammon. Arom., ℥xx.
Aq. ad ℥j.

H. COLLIER.

Obituary.

John Frederick France.

Another link with the past history of Guy's has been snapped by the death, on the 11th inst., at St. Leonards, in his 83rd year, of Mr. John Frederick France, F.R.C.S., formerly lecturer and ophthalmic surgeon to the hospital.

Mr. France entered as a student in 1835, and apparently made good use of his time and opportunities, for he carried off the Physical Society's Prize in Surgery in the session of 1837–8, taking also, in 1839, the Medal for Ophthalmic Surgery.

Securing his M.R.C.S. in 1840, he became shortly afterwards, assistant surgeon in the Eye wards, and in 1847, on the death of Mr. John Morgan, was appointed lecturer and ophthalmic surgeon to the hospital. It is interesting to note that his competitor for one of these offices is still honourably known in the profession in the person of Mr. J. Kellock, F.R.C.S., of Stamford Hill.

In 1853 Mr. France was elected F.R.C.S. and a Fellow of the Society of Antiquaries and of the Medico-Chirurgical Society. Besides editing, with notes, Mr. Morgan's Lectures on Diseases of the Eye, he contributed largely to the Guy's Reports, *Lancet*, and other medical papers.

The fates were kind to Mr. France, and in 1861 he was able to retire, on his accession to a handsome fortune left him by a relative. In his leisure, however, Mr. France found other opportunities of doing good, largely by stealth. A loyal member of the Church of England, he associated himself with all that is best and noblest in her organization and work, and his purse was ever open to the legitimate calls of the sick and needy. In conjunction with another Guy's man, happily still with us, Dr. Edmund Lloyd Birkett, he filled, we believe, in troublous times, the office of churchwarden at All Saints, Margaret Street.

Mr. France was a subscriber from the first to the Guy's Samaritan Fund, and in recent years made handsome donations to the funds of the hospital. As a J.P. and D.L. of Middlesex he was held in the highest esteem by his colleagues, and in his death Guy's may well mourn one of her noblest sons.

H. W.

Mr. France was somewhat my senior, but I knew him well. He was a short man with sandy hair and complexion. After Morgan's death he was appointed ophthalmic surgeon to the hospital, the first special appointment made. He was most industrious and painstaking with the patients and the students. He followed the old methods of treatment, as the ophthalmoscope was not then invented. He wrote several good papers in the Guy's Hospital Reports (Lectures 1840–50), notably one on Syphilitic Iritis and another on Diabetic Cataract. He was impressed with the belief that he was the discoverer of this, as he had already alluded to a case of this kind. He was a shy, retiring man, and never produced much impression on students and patients by his personality. He was then in practice in Bloomsbury Square, but he soon after retired and devoted himself to his favourite pursuit—the study of ecclesiastical history. He was a great supporter of the High Church party, and would sit for hours in the museum with his friend, Dr. E. L. Birkett, the curator, who was of the same persuasion, talking over church matters.

SAMUEL WILKS.

Chapel News.

It will be necessary to close the chapel on Monday, October 29th, for about three weeks, to allow of certain alterations being made in the heating arrangements and for the re-paving of the aisles. During the progress of the alterations the court room will be used for the daily services at 7·45 a.m. and 9·5 and 9·30 p.m. The 9 a.m. and 5 p.m. services will be discontinued, and there will be no services in the court room on Sundays.

By the kind permission of the Rector there will be special celebrations of the Holy Communion, in the Ladye Chapel of St. Saviour's, at 6·45 a.m. and 9 a.m., on Thursday, November 1st (All Saints' Day), and on Sundays, November 4th, 11th and 18th. And on Thursdays, November 8th and 15th there will be a celebration at 6·45 a.m.

It is hoped that the chapel will be ready for use again on or before Sunday, November 25th, when special sermons have been arranged on behalf of St. Andrew's Waterside Church Mission.

The second of the series of monthly instructions on the Holy Communion Service will be given *in the Court Room* on Tuesday next, October 30th, at 8·15 p.m. Subject:—The opening Rubrics of the Communion Service.

Nursing News.

Matron's Office.

The Sisters and most of the Senior Nurses already have their new winter cloaks, and they are undoubtedly in every way a great improvement on the old ones, which have been converted into warm capes for them to wear when crossing to the Chapel, Clinical or Home, etc.

On Friday, October 19th, before the Matron gave her second lecture to probationers and nurses, she called the attention to those present to two notices which they would find on their board in the dining-hall, placed there by the direction of the Treasurer. One discouraging the

practice of present-giving, which has greatly increased of late years, and is found to be a heavy tax upon those from whom contributions are levied; and the other, that the wearing of out-door uniform should be *optional*. Since the formation of the cycling club, the old Guy's rule, that all should enter and leave the Hospital in uniform has been much more constantly broken. The uniform, which is given to the Nurses, will remain exactly the same as before, and they are advised to wear it generally from motives of economy and neatness, but it seems wiser that all should be able to go out in ordinary clothes if they wish. No other out-door uniform, however, than the *Guy's Nurses' uniform* may be worn.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Out-patient Childrens' Christmas Tea.

Dear Sir,—I hope you will be able to spare me space in your columns to ask for help for the Out-patient Children's Tea at Christmas. I do so early in order to avoid unduly clashing with the many other funds which are always prominent a little later. The fund is happily some few pounds in hand from last year, but about £65 is necessary in order to carry it through successfully. May I then ask all to give a trifle towards this most excellent object?

Help in kind, *e.g.*, old clothes (especially boys') will be very welcome and gratefully received by either Sister Out-patients or Sister Jean.

Anyone who can come and help on the actual day will find himself well repaid for his trouble by simply watching the children enjoying themselves. If men will only help as they have done before, there is no reason why the tea should not be as big a success as it has been hitherto.—Yours sincerely,

E. W. GOBLE, Hon. Sec.

Notices.

EXTERN APPOINTMENTS.

In future Extern appointments will be allotted every three months. Application must be made in January, April, July and October.

Guy's Hospital, October 17th, 1900.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Notice is hereby given that the next Primary and Final Examinations for the Diploma of FELLOW will commence on Thursday, November 8th, and Monday, November 19th, 1900.

Candidates are required to give not less than fourteen days' notice of their desire to present themselves for either of these Examinations.

Particulars relating to these Examinations may be obtained of the Secretary (Mr. F. G. Hallett), Examination Hall, Victoria Embankment, London, W.C., to whom all applications in reference to Examinations should be addressed.

The required Fees must be paid three days prior to the Examinations.

October 1st, 1900. Edward Trimmer, Secretary.

LICENSE IN DENTAL SURGERY.

Old Regulations.

Notice is hereby given that the next examination will commence on Friday, November 9th, 1900.

New Regulations.

Notice is hereby given that the First Professional Examination will commence on Friday, November 9th, 1900.

Candidates are required to give not less than twenty-one clear days' notice in writing of their desire to present themselves for either of these Examinations to the Secretary (Mr. F. G. Hallett), Examination Hall, Victoria Embankment, W.C., from whom all particulars relating thereto may be obtained.

October 1st, 1900.

The Golding-Bird Championship Challenge Cup.

The race for the above Cup will take place on Monday 29th, at the Crystal Palace, 3 o'clock sharp.

Mrs. Fripp has kindly consented to be present and to give away the prizes. It is much hoped that many will be present to give her a hearty reception.

British Medical Temperance Association

The annual Breakfast Meeting for Medical Students will be held in the Cannon Street Hotel, on November 9th, at 8.30 a.m. Professor Sims Woodhead will preside, and the meeting will be addressed by A. Pearce Gould, Esq. (Middlesex Hospital), and Mrs. Scharlieb, M.D., M.S. Lond. (New Hospital for Women).

Admission, by ticket only, to be obtained before November 7th, by writing to the Hon. Sec., Dr. Ridge, Enfield, Middlesex.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Passim.

The cold statement that the Students of Guy's Hospital presented Dr. Starling with a silver bowl on the occasion of his retirement from the direction of the Physiological School, can hardly convey any idea of the scene of wild enthusiasm which was enacted in the Great Theatre last Tuesday. We are proud of Dr. Starling, and proud of the honour which he has reflected on the old school, and we demonstrated our pride with right good-will. Ceremonies such as these necessitate speeches, and the speeches, according to custom, must be stuffed with eulogies, but on this occasion the tremendous applause which greeted every fresh tribute shewed that the audience was endorsing every word of the speakers, and that the speeches had the rare quality of expressing the true feelings of the meeting. Dr. Starling's reply brought back vivid memories of the old days in the Anatomical Theatre; the restless movements, the clear incisive delivery, and the quiet gestures with finger and thumb grasping imaginary chalk, all served to remind us of the days when we played with muscle-nerves, straws, and bits of smoked paper in the "long room" of the museum.

Of his speech, it is difficult to give any idea that could convey a quarter of the earnestness and intensity with which he spoke. He told of the small beginnings, the dingy empty rooms, and the long struggle towards the realization of the ideals which he had formed, and then, when at last he saw the laboratories at Guy's the finest in London, the finest, perhaps, in England, he had to break the ties of nineteen years which had bound him to the hospital. And then he told us of his day dreams; of the future of the pure sciences when men would come to the hospital with their groundwork of Physiology and Anatomy set solid for the building up of their clinical experience and with the hospital shorn of its non-medical laboratories, with the inauguration of colleges in the University of London for the teaching of the pure sciences, he hoped once more to meet the Guy's men in the old relations, and in the conviction that his hope would be one day realized, he refused to believe that he had left Guy's for ever, and so for "good bye" he would only say "until to-morrow."

Considered in their entirety, the results of the Final Conjoint Examination are extremely gratifying to the Medical School. There have been, as there always will be, the usual disappointments and one or two unusual developments, but with these exceptions, the list has been a happy one. To those men who have succeeded we offer our congratulations, none the less sincere in that they are somewhat biassed, and to those less happy mortals we offer the true sympathy of experience, with an earnest hope that another trial will reverse the verdict.

It is a curious coincidence that these October examinations, which follow a period of prolonged freedom from tests, revision classes and the like, show a marked tendency to bear better fruit than those which are preceded by a long process of cultivation in the hothouses of revisional tuition. Apparently men have not yet lost the inherent virtue that made one volunteer worth three pressed men, and prefer to absorb their knowledge in their own fashion and in their own time, rather than undergo the intellectual fattening processes which have of late years become so marked. The advocates for freedom of action, and freedom from spoon-feeding—however long the handle—will hail this reaction with joy, and indeed, on the face of it, it must appear that they have good grounds for maintaining their particular attitude. For our own part we have always considered that the pig-at-one-end-and-sausage-at-the-other style of tuition was pushed to a dangerous excess, and we therefore view with pleasure this successful revolt of the unorthodox against the recognised principles of modern scholasticism.

At the best of times, and under the most favourable circumstances of time and place, an examination is a thing to be dreaded, and probably no candidate submits to the ordeal without many misgivings and much pardonable trepidation. To the honour of our profession be it said that the Examiners of the Conjoint Board, as a whole, realize to the full the abnormal condition of the candidate, and while making every allowance for a pulse-rate of a hundred and twenty in a candidate, suppress as far as possible the natural irritation of mind which follows a long course of unsympathetic examinees. In the science and art of Midwifery, however, the Examining Board has earned unenviable notoriety, mainly from the action of one of its members. Whether a man be passed, or whether he be ploughed, he is at least entitled to be treated as a gentleman, and to be exempt from a subjection to petty insults which his

position prevents him from resenting. It should be remembered that no amount of obstetric skill can compensate for a lack of everyday, commonplace manners and that a physician's claims to polite society should not be based solely on an Act of Parliament.

In another column we publish an appeal from Mr. Goble on behalf of the Children's Christmas Tea Fund. Each year has seen a more successful repetition of the first experiment; and each year, unfortunately, the secretary has been faced with the old problem of the quart of liquid and the pint measure. Some, we know, object to these children's teas on principle; but we feel convinced that the most solid objector in theory would be changed into an enthusiastic practical supporter could he be but present when the Christmas tea is given. The poor little children look forward to the treat with feverish excitement weeks beforehand, and after the happy day has passed look back on the one bright spot in their wretched little drab-coloured lives with feelings which we can never realise. The entertainment is a thing apart from the hospital and depends entirely on the disinterested help of friends. Everybody up here can do a little in this matter, either by subscriptions, gifts in kind, or by lending help when it is needed, and we trust that the nurses and men of Guy's Hospital, and their friends, will this year, as in past years, make Mr. Goble's kindly efforts tend to a successful finish.

In the newly constituted Senate of the University of London, we find Guy's Hospital very much to the front. The Royal College of Physicians numbers amongst its representatives Dr. Pye-Smith, F.R.S., of the Consulting Staff, while Mr. Howse, our senior surgeon, has been elected to a seat in the Senate by the Royal College of Surgeons. In addition, Dr. Perry, physician to the hospital, has been chosen as one of the three representatives of the Faculty of Medicine. This is as it should be.

After a proper delay, in which ample time has been given for the conception and maturing of plans for the perpetuation of the memory of those Guy's men who lost their lives in Africa, we have decided to take the initiative and open a subscription list with the object of erecting some memorial to our fallen comrades. The best memorial that we can raise must be the united efforts of all Guy's men, and, with this view, we do not think it will be necessary to specify any limit either way to the subscriptions. A large number of small subscriptions will be more pleasing than a few heavy donations, and we think that there are many men who would desire to join in the testimonial with a small subscription of perhaps half-a-crown, but who would hardly feel themselves justified in subscribing to a list which reckoned in guineas only. However, whatever the sum, large or small, we shall be glad to receive it as soon as possible, and we will acknowledge all contributions in the columns of the Gazette.

The Committee of this Gazette will constitute itself a Memorial Committee and will undertake the difficult task of deciding on the nature of the memorial. It is generally conceded that some form of tablet should be erected, but opinion is divided on the site of such a monument. At present the chapel, the medical school buildings, and the college all claim their particular supporters, and it would facilitate matters if subscribers would indicate any preference that they may have in the matter. The exact nature of the tablet or stone must be left until the size of the subscription list has been estimated. Meanwhile subscriptions should be sent in, and we will once more repeat that they may be as large or as small as the donor wishes.

As far as we know, only two Guy's men, Captain Brailey and Private Glover will be in the ranks of the victorious City Imperials. Still this should serve as an excuse for much lung exercise when they do swing into view. If we are not numerically strongly represented in the battalion we can claim a certain interest in a number of the men who have been lying sick in the Deelfontein Hospital. There, at any rate, the Guy's man came in with some effect.

The Guthrie Society of the Westminster Hospital Medical School announces that the Annual "Guthrie" Lecture will be delivered in the Board-room at the Hospital, on Thursday, November 8th, at 8.30 p.m. Professor Alexander Macalister, F.R.S., will lecture on the "Surgery of the Ancient Egyptians." The Society will be pleased to see any Guy's men who may care to attend. Light refreshments will be served at 8 o'clock.

Modern journalism has, of late years, shown a marked tendency to sacrifice all the decencies

of life on the altar of leaded type. Even Truth, whose person should, above all others, be held sacred by the self-appointed leaders of thought, receives now no more courtesy from certain newspapers than the average politician of the opposite party. There is always consolation, however, in the thought that rag journalism usually manages to trip over its own clumsy feet if it be left to pursue its way unheeded. But in the height of the attack, before the ignorant babbler has met the crisis of his own ineptitude, there is again the danger lest the virulence of the onslaught should provoke a reply to charges that are best unheeded. Thus it is with us, and our calmness has met its own reward, for already the callous, brutal student, who yesterday delighted in the torture of babes and sucklings, to-day stands forward—to serve a purpose—as representing the young intellect of Great Britain. Thanks!

There are two items which should be kept in mind. Firstly, there is the Golding-Bird Challenge Cup Competition at the Crystal Palace on Monday, and secondly, there is the opening night of the Debating Society in the club smoking-room to-night. Dr. Pavy will be in the chair as usual; he has never failed the society since its inauguration; and Mr. Wacher will take the floor punctually at eight o'clock and proceed to demolish the Government with his accustomed skill, incidentally including in the *débâcle* Mr. Thompson and a few other members.

For some reasons best known to themselves, certain persons of no occupation, tailor's apprentices and the like, styling themselves medical students, have thought fit to misconduct themselves in the neighbourhood of St. Martin's Town Hall. Because a foolish old gentleman chooses to exhibit himself in a public hall in preference to the billiard room at Bethlem Royal Hospital, there is no sufficient reason why a number of irresponsible youths should insist upon making nuisances of themselves in public places. This fault would need no comment from us were it not for the fact that the names of great institutions, with which these hobbledehoys claim relation, are dragged into the newspaper police-court reports and awarded the dubious dignity of a place on the display bills. Medical students do not do these sort of things; they have not sufficient money, for one reason, to wantonly waste five pounds on fines, and not sufficient time to undergo a month's imprisonment with equanimity. The average medical student is a well-conducted gentleman, and resents very strongly the doings of these callow youths who smirch his good name.

The Annual General Meeting of the Students' Club will be held in the Physiological Theatre on Thursday, November 1st, at 4 p.m. Dr. Pye-Smith will take the chair. There will be no need to ask that a good muster of men should welcome Dr. Pye-Smith on this occasion. Possibly some of the many grumblers whose reforms are continually voiced, in season and out, may take their courage in both hands and speak at this legitimate opportunity. At any rate, here is an excellent chance for the making public of grievances.

In the *British Medical Journal* for this week appears a series of articles on Plague, which combine to give a good account of the symptoms and bacteriology of this disease, with a short account of its history. This should serve a very useful purpose in supplementing the somewhat sparse accounts in the text-books.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants in the Medical Wards.—Messrs. D. R. T. Griffiths (Dr. Taylor); R. S. Roper (Dr. Hale White); D. W. Smith (Dr. Pitt); R. Thompson (Dr. Perry).

Surgeons' Dressers.—Messrs. F. D. S. Jackson, V. M. Wallis, F. M. Ommanney, A. D. E. Kennard, R. T. Collins, C. H. Gask (Mr. Howse); M. A. Collins, H. A. Cutler, H. Barber, G. F. Humphreys, W. G. Parker, A. H. E. Wall (Mr. Lucas); F. C. Wetherell, D. S. Graves, B. Churchill, M. Coplans, F. Richmond, J. W. Gromitt (Mr. G. Bird); D. H. Trail, W. H. Bowen, C. R. Howard, M. W. Cohen, J. C. Bradbury, A. C. H. Gray (Mr. Jacobson).

Externs.—Messrs. W. J. Davies, J. E. Collins, J. Evans, F. E. Welchman, J. A. Andrews, G. T. Collins (November); M. J. Rees, H. G. Rashleigh, P. J. Nash, A. W. Gater, H. C. Keates, A. C. Nash (December); G. S. C. Hayes, F. A. Beattie, C. B. Penny, E. Bigg, R. D. Smedley, A. W. Soper (January).

Notes from an Ornithological Cruise in the North Polar Seas.

An address delivered at the opening meeting of the Physical Society on Saturday, October 6th, 1900, by Mr. Curtis.

Mr. Chairman and Gentlemen,—When I was asked to read a paper before you I was perplexed about the choice of a subject. It is usual, I believe, for the writers of papers for this society to dive into the fairy-land of pathology, or into some recent surgical romance. I wot little of the fearsome ways of untamed microbes; the ancient history of the vermiform appendix, or the causes of intestinal colic in the human boy, seemed wild and presumptuous themes for me to pursue. So I determined to give some account of a voyage into the Arctic seas in 1897.

The narrative of such a voyage is not easily condensed into the compass of a short paper. As the expedition was chiefly an ornithological one, I shall allude in some detail to the bird life.

The party consisted of Mr. H. J. Pearson, who entirely organised and equipped the expedition, Colonel Feilden, who had in 1875 reached a latitude of 83° 20′ from the "Alert," under Sir George Nares, the record towards the Pole until Nansen established his, and myself, making the third member of the party. With a Norwegian captain and crew we numbered fourteen souls.

The primary object Mr. Pearson had in view in fitting out the expedition was to extend the ornithological observations made by him on the coast of Russian Lapland, the Island of Kolguev, and Novaya Zemlya during the summer of 1895, and especially to push on if possible to that part of the great tundra of the Samoyeds in Siberia in Europe, stretching from Petchora to the Ural Mountains. This it was thought might prove golden ground for ornithological work, as in that respect it is virgin soil and there was some hope that the eggs of the curlew sandpiper—quite unknown to science at the time of our departure from this country—might there be met with. It was known, however, that the coast is a difficult one to negotiate, being very shallow, and the position of the drift ice and polar pack also gave rise to considerable uncertainty as to our final destination.

The vessel chartered for the work was a stout timber built sealing ship, owned in Tromsö, of one hundred and sixty tons register; she was especially stiffened with heavy transverse baulks of timber, a three inch oak skin, and the bow shod with iron to permit of progress through somewhat heavy ice. An auxiliary engine and boiler were put into her and her rig in consequence changed from brig to brigantine. Although devoid of the luxury of an English yacht she was made comfortable and well adapted to our requirements.

We left Bergen on June 4th. Jubilee day was loyally kept in Barent's sea, the ship decked, and a salute of twenty-one guns fired.

We sighted S.W. point of Kolguev June 25th; no floe ice was about, but there was ice stranded ashore. Next day we got amongst drift pine logs; the water was thick and of higher temperature than off the mouth of the Petchora.

27th. A clear, calm, Sunday morning with a very cold wind; our passage was barred by floe ice.

In the early morning the blink was seen, then with glasses a long line of glistening specks on the horizon and at noon we were at the edge of the pack. Some floes were of several acres in extent, and others only huge blocks about eight feet thick, often piled piece on piece, no doubt bay ice of one winter's growth.

We steamed S.E., but the ice was too heavy, so we anchored to a floe, to await its opening out; the pack stretched from N. to E. and S. as far as eye could see from the mast head. When it opened a little we pushed on, worming our way amid the slipping and crashing floes, avoiding the larger ones and charging the smaller; these made the ship quiver and would throw one down if unprepared. The vessel often stopped dead with her nose in a block and sometimes required the engine to back her out. Course was laid S.S.W., but finding the ice again impenetrable, and getting no sign of land, we steered N. again, along the edge of the floes. Becoming impatient, we made another effort to push through the pack, and while battling with the ice, fog came down on us. The next eight hours were full of excitement as the ship had made considerable way into the ice, which had closed behind her and was growling ominously in our wake as it began to feel the pressure of the main pack. When the fog rose, land was sighted, which proved to be the north end of the Island of Waygatch. From the mast a large clear bay was seen, and into this we ran and dropped anchor in four and a half fathoms, behind a small island. Here we were imprisoned for ten days, the ice pouring into the bay in such quantities as to endanger the vessel. The weather was glorious, day and night the sun remained well above the horizon and for almost a week we were in perpetual sunshine without a cloud. All this time was spent working hard among the plants and birds and rocks of Waygatch.

On July 9th the ice opened and we were able to leave. We attempted to land in a bay forty miles to the south, but only succeeded in running the ship aground; fortunately there was no wind and the heavier ice was away, and after some hours of hard work we got her afloat.

We then ran into Yugor Strait, between Waygatch and the Siberian coast, and anchored. On the main land opposite is the town of Habarova, from which Nansen shipped his sledge dogs. It is the metropolis of this almost uninhabited region and consists of seven Russian log huts, one new church, another in ruins, and some half dozen Samoyed chooms. The Russians only live here during the summer months. After working carefully over the south end and east side of Waygatch and

the mainland coast, an attempt was made to get to Khapidirsk Bay and the desired tundra, but when twenty miles from the river mouth the lead gave us only three and a half fathoms where the Russian charts made six, and as a stiff north-west wind was gathering we were forced to make all speed into deeper water. It is clearly impossible to reach this coast except overland.

So all chance of finding the curlew sandpiper eggs was destroyed, and as luck would have it they were found further east at the mouth of the Yenesei by another ornithologist and exhibited in London on our return.

We then ran N. Neptune is an exacting god, some of us paid toll everywhere. We touched at a couple of uninhabited islands off the Novaya Zemlya coast and on July 26th, anchored in Matotschkin Scharr, the long narrow strait between Novaya Zemlya and Lutkë Land, which leads through from Barent's into Kara Sea. The scenery here is magnificent, the strait, about sixty miles long and often less than one mile wide, winds between the mountains of these two big islands. In most of its extent there is no beach, the black crags, too steep for snow to settle upon except in patches, often descend one thousand feet sheer into the sea. The interior of Novaya Zemlya is almost certainly ice capped. The North Island of Lutkë Land is entirely glaciated as soon as the first mountain barrier is passed: in several places in the Scharr this permanent ice cap, which buries beneath its level whiteness the summits of mountains three thousand feet high comes down as glaciers to the water's edge, and during the short summer thaw waterfalls streak some of the crags. While lying at anchor in a land-locked bay ten miles from the east end of the Strait we found among the frost split rocks of a high promontory close at hand a fragment of a wooden tablet carved with Russian characters; near by still leaned a lichen covered pole bearing three grooves which showed it to have been the upright of an ancient Russian cross. On removing a few big rocks, a rough adze-hewn plank was seen, and on raising this there was exposed the perfect skeleton of a big man. He was in a rude coffin, hacked out of a drift log six feet six inches long inside, and his femur measured nineteen inches, making him a man of six feet four inches according to Gray's relative measurements. It was clear he had long been there, the bones were free from every trace of fibre, but although they were large they bore no marks of unusual muscular development. In his pelvis a lemming had made its grass nest a few years before. Close at hand, beneath a few heavy stones, protected thus from the reach of the bears but bearing evidence of the access of foxes, was the skeleton of a boy whose epiphyses had not yet united. Further away, also without coffins and only covered by heaps of rocks, were the skeletons of five adult men. Below, on a spit of shale, was the ruin of a log hut; this we dug out and there found relics of several kinds; there were wooden cases for spear heads, a rough set-square, boxes and cooking utensils, shreds of cloth and a rough wooden playing board, and other articles. From documents we had on board, supplied by the Russian Government, we made out that this was one of two winter huts built by Lieutenant Rossmysloff, of the Russian navy, in the autumn of 1768, that the coffined bones were those of Tschirakin the pilot, who, as Rossmysloff says in his log, "was a very big man and died suffering great pain, on 17th November, 1768." Of the other bones, two were of men killed the same winter in an encounter with a bear, one died of privation, and the remaining two were lost in a snow drift while trying to kill reindeer. This expedition had sailed to look for precious ores and to discover the land, which was but little known. Their crazy vessel was of but ten tons, and that in spite of the proverbially boisterous weather usually met in Barent's Sea. The crew consisted of twelve men besides himself; to accommodate all a second hut had been built five miles east on the opposite shore of the strait. At this latter place we found a rude cross erected by Russian walrus hunters, in 1889, to the memory of these men. The whereabouts of the first hut and of the dead men's bones had been lost sight of by the Russians, although the wooden tablet bore an inscription to the memory of Tschirakin under the date of 1830. Rossmysloff himself, with his numbers reduced to six, attempted further work in Kara Sea in the summer of 1769, but his vessel had to be abandoned in the ice, and after losing yet another man he fell in with a walrus hunter in the south of Novaya Zemlya, and was taken back to Archangel, where he succumbed within a month as a result of the privations he had endured.

For the second time only, in all the history of navigation in these seas, we found Kara Sea free from the dreaded heavy pack of the polar ice, and so were able to cruise up the east coast of Lutkë Land as had never been done before. Icebergs from the Lutkë Land glaciers were the only ice encountered; some of these were sixty to seventy feet high, and some aground in forty fathoms of water, and of the intense blue colour of crystals of copper sulphate. In latitude 74° 24′, we came upon a large bay which had never before been described, this coast line being uncharted. We named it after Ziwalka, a Russian navigator of repute. At its head, a glacier comes down to the sea from the ice cap, and this was named Ibis glacier after the journal of British Ornithology.

Traces of ice bears were here on every side; in one huge ice cavern in the glacier I came upon the fresh spoor of a biggish bear, but did not find him. The knowledge of the valuable means of defence discovered by the great Baron Munchausen was consoling to one among these frequent signs of bear life. You may not be familiar with his treatment; briefly, it is as follows: the enraged beast—it was a lion which attacked him—advances mouth open. Deftly thrusting the hand and arm down the creature's throat, the epiglottis is depressed, and so the mouth is kept open by reflex action, the intelligent forefinger is guided by the bodies of the vertebræ to the root of the tail; this is then seized, and by a *tour-de-maître* the creature's entire latter end is

invaginated, and the now repentant animal is thus delivered through its own mouth. He then rubs its visceral surfaces briskly in sharp sand, and, by a dexterous movement, completely reduces the deformity, so that the animal is once more restored to its pristine state. I understand death to follow as a result of stimuli set up in the splanchnic area which reach the cardio-inhibitory centre of the medulla.

Having built cairns to contain records of our observations on several prominent headlands, we sailed homewards, retracing our old course.

The following account of the bird life of the islands and mainland visited can only be a very meagre summary. Parts of the ground covered had already been roughly worked. Out of a known total for these regions of ninety-two species we observed sixty-five and added twenty other species, besides special records from Dolgoi and the mainland. This, I think, will show that we were not idle, when it is remembered that the ninety-two recorded species are the result of the combined work of five previous expeditions since 1837. The little stint was one of the most interesting species met with; nearly everywhere over the tundra it was the "sparrow" of the country. The eggs of this bird were first found in Europe in 1875, and are still very highly prized. It is the smallest of all the British wading birds, being only four inches long and exceedingly tame. In the grass its habits are almost mouse-like. The extraordinary diversity in the colour of its eggs which resemble those of the common plover in miniature, raised the still debated question of voluntary control of colouring by the birds. Of six clutches taken on peat among rank sedge and lichen the colour was dark, and the blotches heavy and nearly black, which was strikingly protective. Again, among seven clutches taken within two hundred yards of the former but off shingle, the ground colour was pale and the markings mere speckles. These eggs again were not easy to see; but a reversal of clutches and surroundings at once destroyed all the protective qualities of the colouring. My own belief is that the bird does not control the colour of its egg, but that it always produces eggs of one type and chooses its nesting site to suit their colour.

Temmink's stint, ruffs and purple sandpipers were common locally. The dotterell was widely distributed, and several clutches of its particularly handsome eggs found. The red-throated pippet, the snow bunting and red-necked phalarope were also common small birds. Snowy owls were common, and although several old nests were seen, not a single egg was taken. The nest is a large scraping on some mound in the tundra, with a few bones of lemmings and snow buntings lying about it. The mound on which the nest is placed is usually riddled with lemming holes, so that the bird has not far to seek its prey. It is a curious fact, one I believe entirely substantiated by our observations, that the snowy owl does not breed unless lemmings are plentiful enough to eed a brood. No such provident forethought has been recorded from the Boro'! Peregrines were twice seen, and one nest was taken. Rough legged buzzards were perhaps the commonest birds of prey, and here are photographs of a pair of nestlings brought home to the Zoo. A white tailed eagle was seen once on Waygatch. Both bean and white-fronted geese were common on Novaya Zemlya and Lutkë Land. By an extraordinary arrangement their flight feathers are moulted all at one time, so that for ten days they cannot fly, and I am afraid our visit must have left them reflecting sadly upon this phenomenal proceeding. Being without fresh meat, except such salmon and seals as we could kill, these flightless geese got rather badly punished, and some forty odd were brought on board. A swimming goose when pressed, dives with remarkable skill, and swims only with the head above water, this in a sea-way is not always an easy mark. On land they were almost secure, as they will run for miles at such a pace over the soft tundra and broken rocks that a man cannot catch them up. Bewick's swan, longtailed ducks, mergansers and goosanders, the common eider and the king eider were all recorded. The latter were seen in enormous numbers in Matotschkin Scharr, a rough estimate of three flocks gave about five-hundred birds in each. Five birds of this species, shot out of a flock of fifteen amongst the pack ice in Barent's Sea over fifty miles from land, and in ten fathoms of water, had in their crops a number of undigested bivalve molluscs, for which they probably dived sixty feet to the bottom.

In latitude 74° 24″ we found the ivory gull common, and although many specimens showed incubation spots we were unable to locate the nesting ground.

The Glaucous gull is also common and is a magnificent bird. The great black-backed gull is, I fear, driving it from Norway, but as this latter species has not been seen east of the White Sea, it is to be hoped the Glaucous will hold its own.

Of divers, the red-throated was by far the commonest, and on Dolgoi Island, only sixteen miles long, we found almost as many pairs, and continually the eerie wailing of this bird alone broke the deathly silence of these inhospitable lands. The black-throated diver was seen and its eggs taken, but neither of these species could compare in interest with the gigantic colymbus adamsi, the white-billed northern diver, which seems to entirely replace in these waters the great northern diver (colymbus arcticus).

In this land of bird life, however, nothing could compare with the enormous rookeries of Brünnichs guillemot. This is a rather larger species than the common British one, and the cutting edge of the upper mandible is marked with a white streak. On the Novaya Zemlya coast and elsewhere we visited colonies. While yet two miles from shore the sound of the birds calling and crying was like the baying of a pack of hounds across a distance; the air too was full of birds flying hither and thither, and a strong pungent smell was very noticeable. The cliffs for five miles were white with birds and their excrement. On landing the noise was simply deafening, every rock was thick with evil-

smelling slime, and if in climbing you put your hand too near a nestling, a vicious old parent or neighbour would nearly transfix your hand or finger with his beak. Ledge after ledge was so crowded with birds that those constantly arriving would settle plump upon the backs of the others already there. It was not possible to frighten them, except by the noise of a gun shot, and then only a fraction of the birds would fly. So many, however, flew down to the sea at one report that they collided with one another in their flight, and when the main body had swept out, nearly fifty maimed and crippled birds lay upon the water, with wings broken by striking against their neighbours. Two birds flying from opposite directions collided with a thud above my head, one was killed outright and the other left gasping in extremis. Never could I have imagined such a vast colony of birds, they filled the air like a cloud of gnats.

There are but one or two matters connected with the flora of these islands that I will allude to. There is, of course, no wood whatever growing so far north; the largest tree discovered during our wanderings is now upon the table. It is a birch tree, which was creeping upon the ground like ivy, scarcely one inch high, and only nine or ten inches long over all, yet a careful examination of the rings in its stem shows it to be, roughly, thirty years old. Upon the table are specimens of the more characteristic flowers; here and there in sheltered places you might find a square yard or so ablaze with colour. In all, one hundred and ninety-seven species were recorded. Of course, the plants were nearly all extremely dwarf, few growing more than six inches high, and many creeping low over the stones. As Col. Feilden has pointed out, the distribution of plants has an important bearing on the somewhat vexed question of the glaciation of these lands in ancient times. This question is not one into which I can enter, but the point of special interest lies in the fact that a double flora seems to exist, and to have existed in geological ages in these high latitudes. In spite of the glaciation of Scandinavia and the submergence of Arctic Russia beneath the sea, some nucleus of a flora has been preserved on the mainland, which has now largely supplied the plant life of Dolgoi, Waygatch, Novaia, Zemlya, Lutkë Land, Spitzbergen and Franz Joseph Land. On the other hand, a true circum-polar flora appears to have existed which must throw doubt upon a complete polar glaciation at any one time. Relics of this flora appear in Greenland, Grinnell Land, Spitzbergen, Franz Joseph Land and Lutkë Land, which do not appear anywhere upon the mainland of Europe, Asia or America.

The vertebrate fauna, apart from the birds, is fairly extensive. Ice bears must be common in the winter and spring, judging by the footmarks, excrement and bones frequently found. Only one was actually seen, he was a big fellow, his foot-prints were ten inches across, but he was not secured. Walruses are fairly common off the East Lutkë Land coast. Seals of several species abound. In Barent's Sea whales of apparently two or three species exist, although the rorqual and lesser rorqual were the only ones identified at the whaling station we visited at Scaro in Norway. One hundred and twenty-nine were killed there in the previous season, which only lasts through the months of July, August and September. They are shot by a five foot long harpoon fired by a gun with a three-inch explosive shell in its head and four barbs, each two foot long, which, upon entering, spread out as a cross and so completely anchor the creature, there being a stout hawser attached. In one whale caught while we were there a five-foot fœtus was discovered; it was vermilion in colour and strikingly torpedo-shaped. One could not help reflecting how desirable was this provision to facilitate parturition, for these creatures outside "the boundary," and so debarred from the skilful and sympathetic aid of the worshipful Company of Externs. I meditated how the resourceful cunning of one of these specialists when confronted with a funis to strangulate thicker than his wrist and as tough as a hawser would prove itself adequate to every emergency!

Reindeer were evidently plentiful still on Novaya Zemlya, as one family of Samoyeds killed over two-hundred the previous winter. The Arctic fox was fairly common, and although we saw several, we could never get a shot at one. Lemmings were surprisingly scarce, we only saw two altogether; they are two-thirds the size of a rat, with only a short tail, and the fur is of a rich golden brown colour. In some years they overrun the whole country in great armies, and will even advance into the sea, like the Gadarene swine, and so are drowned by the thousand. Two species of fine salmon occur in these waters, S. omyl and S. alpinus, the first has white, and the latter pink flesh.

With a short reference to the people of these regions, I will conclude. So far as the Government goes, it is entirely Russian, but there is no Russian settlement north of Habarova, on the mainland, although on Novaya Zemlya there is one family of half-breed, Russians and Samoyeds. The Habarova Russians are all men, they are there only for four months, coming overland on reindeer sledges before the summer thaw, and leaving again as soon as the rivers freeze in early autumn. Those we saw were all fine big fellows, clad in the skins of reindeer, bears and seals. They are superstitious, and pay frequent devotions to pictures of their various family saints. A dose of phenacetin given to their head man, which cured a headache he said he had had for ten days, won expressions of surprising admiration and gratitude. We were to take tea in his hut; a pale straw-coloured fluid infused from leaves brought overland from China, through the markets of Siberia, and highly prized. The tea they usually drink is brewed from leaves of some sort made up into cakes with the fat of seals; a lump is cut off as required, and infused in boiling water. We had set before us the luxuries of his cabin, dry hard bread-crusts, brought on sledges from Petchora in the spring, one-hundred miles away. Candied sugar and dried fish. They were very friendly, and assisted us as

much as they could, on one occasion by their help saving our steam pinnace from being wrecked on shore. The head man showed us with marked pride a big gold medal presented to him by the British Government for saving the lives of Captain Wiggens and forty men who lost their ship in the ice near Habarova.

The Samoyeds are the real inhabitants of this region. They correspond apparently to the Lapps and the Esquimaux. They were originally driven into the north by the Turco-Tartar races, and now are thinly scattered along the arctic coast west of Yenesei. They are a dwarf race, we saw none over five feet, and four feet eight inches or four feet ten inches was the more usual height. They are of Mongolian type, high cheek bones, slit black eyes, and long, straight, black hair, with a sallow or coffee-coloured skin. Whether the colour would fade under treatment with soap and water I cannot say; the experiment has probably never been tried. They live in the summer in chooms built of a stack of poles covered with skins and mats, the smoke, or some of it, retires through a hole in the roof, most of it follows you round the tent. A few families in the north of Novaya Zemlya had good log huts built for them by the Russians, who send them there to winter, to kill deer and bears for them. The rest winter in huts largely built out of the snow. Their dress is entirely of skins, the ladies adorning theirs with sma bits of coloured rags; except for this there seemed be no difference between the dress of the man and is wife. Most of the work and the bargaining seemed t be left to the women. All their tools and implements were made from the bones, horn, teeth, tusks or hides of animals slain, or from driftwood. They hunt with crossbows and old muskets supplied by the Russians, and they are aided by a pack of twenty to thirty big, rough coated dogs, whom they do not feed, but leave to forage for themselves, and discipline largely by stone throwing. They are, in consequence, very savage and treacherous. The Samoyeds are practically the serfs of the Russians and work for them as such. Their food is almost entirely the flesh of the animals and fish they kill; a bowl of warm blood is what they chiefly relish. A man and his family will settle down to eat a reindeer, and with only very trifling intervals go on till it is all eaten, they will then go for several days without food. A strip of raw seal blubber is a delicacy they are also fond of, quite small children were seen chewing the end of a good thick strip, which they would finally entirely devour.

They seemed, as far as it was possible for me to judge, remarkably free from illness. Small-pox is said to occur among them, and on one occasion, the magic of the phenacetin having been noised abroad, I was begged to prescribe for an old woman with hæmoptysis. The cause I had no means of discovering, but thought it phthisis. As fee, I was pressed to accept five salmon and two cakes of seal blubber. They are extremely superstitious and wear all manner of charms, bears' teeth being thought most efficacious apparently. Their language is entirely unwritten, and I believe is not even known to the Russians. On Dolgoi Island, fifty miles from the coast and without inhabitants, we found three Samoyed graves. They were all above ground: two adults were contained in boxes among some rocks, and one child was beneath a rough erection of logs. They had all been there for many years. They had been buried in their deer skin cloaks, and with them there were utensils for food, harness for reindeer sledges and weapons. Close at hand were some broken sledges and a pair of rough paddles, all to be used by the departed in the Hereafter. At the time of burial, it is said, reindeer are sacrificed to go with the hunter and draw his sledge. Thus lives and dies Homo Sapiens Samoyedorum.

Reviews.

The price of books submitted for review should in every case be stated.

A Manual of Physiology. By G. N. Stewart, D.Sc., M.D. Fourth Edition. (Baillière, Tindall & Cox. 1900). Price 15s.

The fourth edition of this text-book maintains those qualities which have won for its predecessors a place in the library of the University student. Forty-three pages have been added and there is an increase in the small print; hence a considerable amount of new matter is presented, and among this the following are a few of the notable points.

Under the heading of Digestion, Pawlow's proof of the secretory action of the vagus is inserted, as is the work of Starling and Bayliss on the intestinal movements. The advances made by recent workers in the problem of the internal secretions have been noted, and there are additions to the text relating to the metabolism of iron, heat production, and the histology of contracting muscle. Under the latter heading the views of Rutherford and Schäfer have changed places, the latter being now given the honour of precedence.

In treating of the formation of lymph, the observation that when sugar is injected into the circulation it may be found in larger quantity in the lymph than in the blood is again mentioned, but the explanation of this fact furnished by Professor Starling is omitted.

The account of the central nervous system is amplified, and is improved by several good diagrams; those of the cortical centres in the monkey, of the histology of the olfactory bulb, and of the central connections of the fifth nerve should prove useful, and although the last-named is incomplete we wish that even a similar diagram of the eighth nerve had been included. Mention is made of Schäfer's observation of the destination of the pyramidal fibres in the cells of Clarke's column, but Lloyd's experiments showing the origin of the antero-lateral descending tract from Deiter's nucleus are not described.

We noticed "gummæ" for "gummata" on page 203, and "tendinous inscription" for "tendinous intersection" in the chapter on nerve.

On the whole the book is one of the best of its kind, though its increasing bulk will endear it less than ever to the average Conjoint man.

Notes on Physiology. By Henry Ashby, M.D., F.R.C.P. (Longmans). 7th edition.

In 389 pages, and those of a small size, the student is here presented with a series of facts summarizing physiology and histology for examination purposes. The print is good, and there are plentiful illustrations, and efforts have been made to keep the information contained up to date. Since this is the seventh edition it is evident that such a volume as this is of use to many, though we should have thought that a man's own notes, made in the laboratory and the lecture theatre, would be more easily understood and assimilated during those last few feverish days which precede an examination.

Synopsis of the British Pharmacopœa. By H. Wippell Gad, M.P.S. Fifth Edition. (Ballière, Tindall & Cox.) 1s. net.

Of the making of books there is no end, and of the varieties of the pharmacopœa there is number infinite.

The particular species now before us is primarily intended for chemists; is neat, compact, and has evidently, as the author claims, "met a want," since it is now in its fifth edition. All the drugs, and their preparations, are tabulated alphabetically with characters (compressed) and imperial and metric doses. A fifth column of pithy remarks completes the tale. A few useful tables are also included.

Materia Medica, etc. By W. Hale White, M.D., F.R.C.P. Fifth Edition. (J. & A. Churchill, London.) 7s. 6d.

This edition of the British Pharmacopœia is too well known to need much notice from us. It has long been the standard manual for University and College examinations, and has in addition the special merit of having found favour with the great body of post-graduates. The scholarly and scientific treatment of the physiological actions of drugs and the eminently practical sections on therapeutics, recommend it alike to student and practitioner.

Also received.—Some Remarks on the Treatment of Heart Disease, with special reference to the "Hill Heart," reprinted from the "Lancet," September 8th, 1900. By H. J. Campbell, M.D., F.R.C.P. Lond., Senior Physician to the Bradford Royal Infirmary and Lecturer on Forensic Medicine in the Yorkshire College, Leeds. Hospital (weekly), Clinical Journal (weekly), Treatment, St. Bartholomew's Hospital Journal, St. George's Hospital Gazette (2), St. Mary's Hospital Gazette, Climate, Polyclinic Medical Temperance Review.

In Lighter Vein.

THE DEN OF THE DEMON DEAN.

A Comedrama.

Scene—*Schedule Land.*

Time—*Flies.*

Dramatis Personæ—*The Demon Dean and some Mortals.*

[*The Curtain rises on an Interior. An odour of justice, tempered with mercy, pervades the atmosphere. On the walls are hung some birch rods, a few framed epigrams and proverbs (such as "A wise Chronic makes the Dean laugh," "A sense of humour is better than many lectures," etc.), and some bottles containing pathological specimens, labelled "Healthy Half Hours." At a desk up stage centre sits the Demon Dean himself. Blue limelight effects.*]

The D.D. (*loq.*): There is no doubt lectures *are* a relic of barbarism—and really—well now—come, I think I'll sign them all up (*does so*).

[*Loud knocking without. Limes turn suddenly red.*]

The D.D.: Some one has passed my Geni(tor)—bother—come in.

[*Enter a Son led by a Father (green limes on Son).*]

The D.D. (*rising*): Good morrow.

The Father (*depositing Son in a corner*): How de do? I'm anxious to place at the disposal of my son all the advantages obtainable from being a student of Guy's.

The D.D.: Very wise. Very wise. You know our new regulations.

The Father: No, Sir. I came to enquire about them.

The D.D.: Ah! Yes, certainly. Is your son a Fellow of the Royal Society?

The Father: Good gracious, no. He has an excellent college record, and has won many scholarships, but beyond that——

The D.D. (*with assumed surprise*): My dear sir, are you not aware that for your son to be

admitted to Guy's he must already be a Fellow of the Royal College of Surgeons and a Doctor of Medicine, and that before being allowed to join any of our classes he will be required to write an original treatise on the subject in which he is about to be instructed?

The Father: Good gracious!

The D.D.: If your son were an F.R.S., or the president of a great learned body, we might stretch a point, but a good college record—— Pooh! Pish!! Tush!!! (*Rapidly changing variegated lights.*)

The Father: Good gracious!—but—what rot!

The D.D. (*genially*): Yes, is'nt it (*recollecting himself*). I mean, is'nt it a blessing we have a wise and logical board to regulate these things for us?

The Father (*dubiously*): Hum.

The D.D. (*sagely*): Ah! Indeed!

The Father: But look here; where can I get my son educated, in medicine? This *is* a School, is'nt it?

The D.D.: Well, it *was;* but I'm not quite sure what we call ourselves now. However, as I have told you, we will gladly teach your son—provided he knows all the subjects already.

The Father (*a purple light for him*): I—Well—Good gracious—Umph—(*to son*)—Come along, Algy; we'll go and make a corner in pork.

The D.D. (*sadly watching them go*): Well, its not my fault. (*Sighs deeply.*)

[*All the lights go out and the curtain falls to the strains of the "Dead March in Saul" (on mouth organ) heard off.*]

J. U. G.

Papers by Guy's Men.

With Dr. Savage at Bethlem Royal Hospital.—*Clinical Journal*, October 3rd.

Clinical Lectures on the various forms of Intra-Abdominal Suppuration. By A. H. Tubby, M.S., F.R.C.S.—*Clinical Journal*, October 3rd and 24th.

Three cases in which the Superior Cervical Ganglion of the Sympathetic was removed, with remarks upon the operation. By F. F. Burghard, M.S. Lond., F.R.C.S. (Illustrated).—*British Medical Journal*, October 20th.

Sport.

Rugby Football.

GUY'S v. LENNOX.

(Guy's, 5 points; Lennox, nil).

Played at Stamford Bridge on October 13th. Lennox kicked off against the wind and Louisson returned. Several scrums now took place on the half-way line, but neither side could gain any advantage. Soon the Guy's team were attacking, but Brown missed a few passes thrown out from the scrum by Louisson, and so the three-quarters got no opportunities to score. Lennox worked back to half-way, and their three-quarters started passing; O'Brien and Pye-Smith, however, managed to stop the centres before they became dangerous. Good runs by O'Brien, McEvedy and Pye-Smith took play back to the Lennox twenty-five, and from a scrum Anderson got the ball and dribbled past the three-quarters and full-back, and scored. O'Brien converted with a good kick. Half-time was then called, Guy's leading by 5 points to nil.

On changing ends, Lennox pressed, but good tackling by Guy's kept them out. Now Guy's took a turn at attacking, and Thompson, after a good run, nearly scored. Their three-quarters again became dangerous, Harrison bringing off a splendid tackle when a score seemed certain. Play was now on our line, but McEvedy cleverly intercepted a pass, and took play to the other end. Lennox again pressed us, but when time was called we were still leading by 5 points to nil.

Remarks.—The forwards played very well right through the game. Louisson was the better of the halves. The three-quarters passed well when they had a chance. Harrison was sound, as usual. Team:—

Guy's.—E. M. Harrison (back); J. T. Hicks, C. D. Pye-Smith, A. O'Brien, P. F. McEvedy (three-quarter backs); M. G. Louisson, S. C. Brown (half-backs); H. A. Cutler, M. A. Collins, R. C. Lawry, E. H. B. Milsom, R. G. Anderson, A. R. Thompson, B. Glendinning, A. H. E. Wall (forwards).

GUY'S v. CATFORD BRIDGE.

(Guy's, 6 points; Catford Bridge, nil).

This match was played at Catford before a capital attendance, which included many Guy's men. Catford winning the toss, elected to play with the wind, and Lawry kicked off for the hospital. At once Guy's began to attack. Brown smartly got the ball away to Louisson, who made an opening for Pye-Smith. He gave the ball to O'Brien, who in turn passed it to McEvedy. The last named made a dash for the line, but was tackled. Catford were now penalised for off-side play, and O'Brien with a splendid kick gave Guy's a 3 points lead. Catford now bucked up, but still the Hospital had most of the game. Just before half-time Brown made a good run up the field and passed to Watts, who was in close attendance.

He in turn gave up to Hicks, who punted over the goal-line, and so obtained a minor. Half-time saw Guy's leading by 3 points to nil.

At once Guy's again got into full swing, and the three-quarters brought off several pretty rounds of passing. Play settled down in the Catford twenty-five, and from a scrum Brown threw the ball to McEvedy who was waiting on the blind side of the scrum. The latter dashed for the line with two or three men hanging on to him, and scored far out. O'Brien failed to convert. Urged on by the shouts of their supporters, the Catford forwards now went away with a rush, but a forward pass stopped their chance of scoring. Good kicking by Lawry, O'Brien, Harrison and Pye-Smith, drove them back. From now to the end the Hospital attacked strongly, but failed to increase their lead. Time after time the ball was smartly heeled out by the forwards and the three-quarters set going, but bad luck stopped them scoring, and at the call of time Guy's had won by 1 penalty goal and 1 try to nil.

Remarks.—From the start Guy's showed splendid combination, and kept it up to the end. The forwards all worked hard, heeling-out smartly and bringing off several good rushes. Louisson and Brown backed them up, and time after time set the three-quarters going. O'Brien and McEvedy on the right wing played well, but the other wing did not get much chance of distinguishing themselves. Team:—

Guy's.—E. M. Harrison (back); J. T. Hicks, C. D. Pye-Smith, A. O'Brien, P. F. McEvedy (three-quarter backs); M. G. Louisson, S. C. Brown (half-backs); H. A. Cutler, R. C. Lawry, E. H. B. Milsom, R. G. Anderson, B. Glendinning, A. R. Thompson, H. Watts, A. H. E. Wall (forwards).

GUY'S 2nd XV. v. KENSINGTON 2nd XV.

(Kensington, 8 points; Guy's, 3 points.)

In this match, their first, the 2nd XV. were defeated by 1 goal and 1 try (8 points) to 1 try. Guy's, winning the toss, had the advantage of a stiff breeze behind them during the first half. Play was mainly in midfield and was of a very scrambling order. Jupp eventually run in from near the half-way line and scored a brilliant try. This was all that was scored up till half time.

In the second half Kensington played up well and got over twice, one try being converted. Guy's on one or two occasions carried the ball close up to their opponents' goal line, but failed to get over.

Remarks.—Gardiner proved an efficient substitute for Bridger at full-back. He scarcely ever failed to find touch with his kicks. The three-quarters did not get many opportunities of attacking. The tackling left a good deal to be desired. The halves did not work well together; on several occasions they failed to get the ball away when it was heeled out. The forwards, on the whole, played well; certain of the new men showed some ability. The most noticeable mistake was a tendency to kick the ball hard into the hands of the opposing backs. The team will doubtless get more into shape in the course of a few weeks. A systematic course of attendance at Honor Oak Park will do much to accelerate this desirable result. Team:—

Guy's.—J. J. Gardiner (back); A. E. Kynaston, — Lindsay-Woods (half backs); E. N. Jupp, — Russell, J. T. Hicks, H. S. Brown (three-quarter backs); M. A. Collins, P. N. Blake-Odgers, — Vaughan, G. T. Collins, H. Watts, R. M. Rendall, — Norman, — Wood (fowards).

Association Football.

GUY'S v. OLD HARROVIANS.

(Old Harrovians, 2 goals; Guy's, 1 goal.)

Played at Honor Oak, on 13th inst. Guy's kicked off and began to press, but could not get through the visitors' defence. The game ruled fairly fast and the Old Harrovians scored from a lucky shot towards the close of the first half. In the second, each side scored once, and the visitors thus won by 2 goals to 1. In justice to the home team it must be said that they were not at their full strength, and had distinctly hard lines in not scoring on one or two occasions. Team:—

Guy's—F. M. V. Smith (goal); S. M. Wells, N. P. Shepherd (backs); A. Hogarth, B. Brailey, C. Aubrey (halves); J. Wilson, E. L. Norton, F. B. Manser, T. A. Chignell, D. Berry (forwards).

GUY'S v. IDLERS.

(Guy's, 3 goals; Idlers, 1 goal.)

Played at Honor Oak, on 20th inst. Guy's lost the toss and kicked off towards the Pavilion goal. They began to press almost at once, and after some good passing among the forwards, Chignell was able to score some 10 minutes after the start. The visitors could not make much headway, and were on the defensive most of the time. About half-way through the first half Guy's scored the second goal. Rain came on towards the latter end of the first half and somewhat spoilt the game at this period. The second half was a repetition of the first, Guy's pressing and the Idlers defending, with an occasional run up, from one of which they scored their only goal. The game came to an end, after the home team had scored once more, and Guy's left the field, having won by 3 to 1. This score might have been increased had the outside forwards only centred instead of attempting brilliant but futile shots. Team:—

Guy's.—E. A. Collins (goal); W. M. Robson, S. W. Wells (backs); H. Bacon, J. Goss, N. P. Shepherd (halves); T. Edey, J. Cameron, T. A. Chignell, E. L. Norton, J. Wilson (forwards).

GUY'S 2nd XI. v. NORWOOD AND SELHURST RESERVES.

Surrey Junior Cup.—First Round.

Guy's 9 goals; Norwood & Selhurst Reserves, nil.

This match was played at Honor Oak Park on Saturday, October 13th, and resulted in an easy win for the Hospital by the wide margin of 9 goals to nil.

Kicking off against a strong head wind, Guy's pressed at once, Peall and Dent each getting through twice in rapid succession. Every rush of the opponents came to an abrupt termination at our half-back line, and Collins the home goal-keeper had but few opportunities of distinguishing himself.

In the second half, goals were scored by Peall, Dent, May, Roberts and Smith, the last-named in particular arousing the enthusiasm of the spectators by a somewhat astonishing shot from a corner kick.

Peall and Dent among the forwards, Goss at centre-half, and Crofts at left back, were especially noticeable, but the whole team played well, considering that it was the first time the men had played together. Team:—

Guy's.—E. A. Collins (goal); A. Leeming, A. Crofts (backs); J. Cameron, J. Goss, F. M. V. Smith (half-backs); A. H. Clough, H. L. Dent, W. O. Roberts, W. M. May, P. A. Peall (forwards).

GUY'S 2nd XI. v. OLD FORESTERS 2nd XI.

(Old Foresters, 3 goals; Guy's, nil.)

Played at Snaresbrook, Saturday, October 20th.

Guy's went away with a weak forward line and suffered accordingly, besides being hampered by the inequalities of the forest turf.

Until the second half was twenty minutes old we managed to keep the enemy out, but afterwards they scored three times, whereas we were unable to get through.

Smalley and the backs played a very plucky game. Brailey was the best of the halves, but all three were rather careless as to how they parted with the ball, though they were keen enough in getting it.

Peall worked hard at inside left, and there were four others more or less in the forward line.

Until the men learn to keep the ball low and to pass definitely to one another, rather than promiscuously to the enemy, we shall not see the Cup in the smoke room. Team:—

Guy's.—E. Smalley (goal); A. Leeming, A. D. Crofts (backs); J. Reynolds, — Brailey, T. T. Cole (halves); H. L. Dent, A. H. Clough, F. Fox, — Watney, P. A. Peall (forwards).

Appointments.

CIVIL.

Ashby, A., M.B. Lond., F.R.C.S. Eng., has been re-appointed Medical Officer of Health by the Reading Town Council.

Byford, W. F., M.R.C.S., L.R.C.P., has been appointed Certifying Factory Surgeon for the Ruthin District of the County of Denbigh.

Sturdy, H. Carlile, M.B. Durh., M.R.C.S., L.R.C.P., has been appointed House Surgeon to the East London Hospital for Children, Shadwell, *vice* S. Vere Pearson, resigned.

NAVAL AND MILITARY.

Fleet-Surgeon E. H. Williams has been placed on the retired list at his own request. He was appointed Surgeon September 30th, 1878, Staff-Surgeon 30th September, 1890, and Fleet-Surgeon 4th May, 1899.

Lieutenant C. R. Evans, R.A.M.C., is transferred from South Africa to Devonport, and Lieutenant R. T. Brown, M.B., R.A.M.C., from Devonport to Salisbury Plain.

Births.

NEWNHAM. — On October 21st, at Chandos Villa, Queen's Road, Clifton, Bristol, the wife of W. H. C. Newnham, M.A., M.B. Cantab., of a daughter.

O'MEARA.—On October 16th (by cable), at Jhelum, Punjab, India, Gertrude Charlotte (née Hollingworth), wife of Eugene J. O'Meara, I.M.S., 11th Bengal Lancers, P.W.O., of a daughter.

Marriages.

GODSON — ENTWISLE. — On October 3rd, at the Parish Church, Cheadle, by the Rev. J. Godson, M.A., vicar of Ashby-Folville, rural dean, the Rev. N. Brady, M.A., rector of Wennington, uncles of the bridegroom, and the Rev. F. A. Macdona, rector, John Herbert Godson, B.A., M.B., B.C., Cantab., D.P.H. Camb., second son of Alfred Godson, M.A., M.B., M.C. Cantab., J.P., of Cheadle House, Cheadle, to Alice Maud Grace, the youngest and only surviving child of the late Thomas Entwisle, of Linden House, Cheadle.

ROWLAND—GRAHAM.—On September 25th, at the Parish Church, Acton, Edward W. S. Rowland, B.A., Cantab., M.R.C.S., L.R.C.P., of Western Elms Avenue, Reading, second son of the late Charles B. Rowland, M.A., vicar of Wowerley, Worcestershire, to Annie S. Graham, fourth daughter of the late Professor Graham, D.D., of Liverpool and London.

SALTER—BROWN.—On August 22nd, at Raunds, Northamptonshire, Alfred Salter, M.D., to Ada Brown.

SPONG — PICKERING. — On October 4th, at St. Luke's Church, Newtown, Pennsylvania, by the Rev. Edward Ritchie, Major C. S. Spong, B.Sc., F.R.C.S., D.S.O., youngest son of the late William Nash Spong, F.R.C.S., of Faversham, Kent, to Mary Barnsley, only daughter of the late Henry P. Pickering, of Titusville and of Mrs. Pickering, of Newtown, Pennsylvania.

Death.

TANNER.—On October 13th, Ettie Lilian, eldest daughter of John Tanner, M.D., 19, Queen Anne Street, Cavendish Square, W., in her thirty-second year.

Ed.—S. H.

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Calendar of Coming Events.

November, 1900.

Sat. 10.—Messrs. Jacobson and Fripp's take-in; Drs., C. R. Howard and J. C. Bradbury; Cl., F. W. Sime.
1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., II., Beckenham, home.
III., Richmond St. Mary's, away.
IV., Catford Bridge, III., away.
G.H.A.F.C. I., Eastbourne, away.
II., Woodford Albion, home.

Mon. 12.—1.15 p.m., Clinical lecture by Mr. Brailey.

Tues. 13.—4.30 p.m., Meeting of the Dental Society.

Wed. 14.—1.30 p.m., Clinical lecture by Mr. Howse.

Thur. 15.—Messrs. Howse and Symond's take-in; Drs., A. D. E. Kenward and R. T. Collins; Cl., M. D. Wood.

Sat. 17.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Bedford, away.
II., Old Alleynians, home.
III., King's College Eng. II., away.
IV., Streatham III., away.
G.H.A.F.C. I., Reigate Priory, away.
II., St. Thomas's 2nd XI., home.
Smoking Concert.

Mon. 19.—Final Fellowship Exam.
Cambridge 1st, 2nd and 3rd M.B. Schedules to be brought to the Medical School Office for signature.
1.15 p.m., Clinical lecture by Mr. Symonds.

Wed. 21.—1.30 p.m., Clinical lecture by Mr. Howse.
G.H.R.F.C., III., Tonbridge Sch. II., away.
G.H.A.F.C., I., Nondescript (Camb.), home.

Thur. 22.—Messrs. Lucas and Lane's take-in; Drs., H. Barber and G. F. Humpherys; Cl., J. A. B. Hammond.
G.H.C.U., Missionary Meeting.

Sat. 24.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Old Merchant Taylors, home.
II., Royal School of Mines, away.
G.H.A.F.C. I., Ramsgate, away.
II., Banstead, Home.
G.H.P.P.S., Pathological Meeting.

Guy's Hospital Gazette,

NOVEMBER 10, 1900.

Breast Feeding of Infants.

CLINICAL LECTURE BY DR. PITT.
October 6th, 1900.

GENTLEMEN,—There is no class of cases which, when you get into practice, will give you more trouble than those of improperly fed infants. The child suffers discomfort, is out of health and constantly irritable, thereby disturbing the whole household; and there is no class of cases in which you get more credit when you set the disturbance right.

I propose, therefore, to-day to lay before you certain general principles which should regulate their feeding, as there is no more potent cause of ill-health in infancy than errors in diet. In middle life, the chief causes of illness and death are, first and foremost (*a*) phthisis, which largely depends on an imperfect supply of pure air; and besides this, (*b*) the effects of excesses of all kinds, (*c*) of exposure, and (*d*) of accidents. In old age, the chief causes of death are defective excretion, especially imperfect action of the kidneys; and degenerative changes. But in infancy the great cause of ill-health is imperfect digestion. This is very largely due to the fact that parents will insist on trying to feed children on similar food to what they take themselves. Now, that this must necessarily fail is obvious, when you come to consider the relative proportions of the various constituents, of the food which is suitable for an adult, and those of human milk.

In an average diet for an adult, the proportion of fats to carbohydrates is one to five, whereas in milk it is very nearly one to two; the proportion between the fats and proteids for an adult is three to five, and in milk these are almost equal in proportion. The first thing that strikes you about the constituents of food for an infant is, that a larger proportion of carbohydrates and fats and much less of proteids are necessary than in later life. If you take the total amounts which are required to keep a child under a year old in health, you will find that the child will need daily 20 to 36 grammes ($\frac{2}{3}$–1 oz.) of proteids, 30 to 45 grammes (1–1$\frac{1}{2}$ oz.) of fats, and 60 to 90 grammes (2–3 oz.) of carbohydrates. Whereas, if you take a healthy man in moderate work, he will require,

on an average, 500 grammes (1 lb.) of carbohydrates, 56 grammes (2 oz.) of fats, and 110 grammes (3 oz.) of proteids. Practically, a child under a year old requires about half the total amount of fats that an adult does. It is most essential in feeding children that these facts should be borne in mind.

A very large proportion of the children that attend at out-patients are suffering from the effects, directly or indirectly, of erroneous feeding. A number attend on account of defective nutrition, many for rickets, and others for diarrhœa. These practically form the great majority of out patients at a children's hospital. If parents were careful about the feeding of their children, the attendance at a children's hospital would be a very small fraction of what it is at present.

The mortality of infants is enormous. In some crowded parts of manufacturing towns no less a proportion than one-third of all the children die within the first year after birth, and throughout the kingdom one-fourth die within five years. The chief cause which determines the mortality is, in many districts, attacks of diarrhœa. In the summer, during the hot weather, you very often have the mortality of a whole city increased simply from the deaths of infants that occur during a few weeks, and in almost all cases this is preceded by chronic diarrhœa. When diarrhœa is attended to at its onset, the number of cases of acute fermentative diarrhœa are comparatively few. Therefore, it is a very important question indeed that we have to discuss to-day.

I propose first to deal with the feeding of children on breast milk. In the majority of cases, provided certain rules are carried out, there is comparatively little difficulty in bringing up the children. But in a certain number of cases you find that things go wrong, and therefore it is very important that you should know whether they are remediable, and if so, what treatment is to be adopted. Children at birth have a very small stomach. During the first week the stomach of a child will only hold one ounce of liquid, at the end of about two months it will hold two ounces, and at the end of about five months it will not hold more than four. That is to say, there is not a very rapid increase between the second and fifth month. But between the fifth and the tenth month the stomach more rapidly again increases in size until it will hold from eight to ten ounces.

The daily amount of milk secreted after the first few days is about one and a half or two ounces, and after the first three months the breast can secrete from thirty-six to forty-eight ounces of milk. But it is probable that only a portion is drawn off, as it is comparatively rarely that the full amount that can be secreted, is consumed. During the first twenty-four to thirty-six hours most children require nothing at all, and it is a great mistake to give sugar and butter, a popular prescription, as that only upsets them. The alimentary canal of a newly-born infant is filled with meconium, and during the twenty-four hours or so which is necessary to allow this to pass off, the child can very well do without any food whatever. The first secretion drawn off, colostrum, acts as a laxative and helps to get rid of the meconium in the alimentary canal; it contains some 8 per cent. of proteids. The secretion of the breast is not fully established until the third day. A child will take about one pint of milk at the end of ten days, and later on up to about three pints. A rough but convenient rule for regulating the feeding is, that during the first fortnight a child should have a feed about every hour, at the end of the second month about every two hours, at the end of the third month about every three hours, and at the end of the fourth month about every four hours; assuming that you are dealing with an average child. Accustom the child to have only one feed at night at the age of three months, and after six months none between 10 p.m. and 5 a.m. This is as important for the mother as for the child, as the supply of milk is greatly improved when the mother has an unbroken night's rest. Make it also an invariable rule that the child shall never sleep in the mother's bed.

A curious fact has been pointed out, that when a child is very small in weight and far below the average in size, the size of its stomach is the same as that of an average child of the same age. That is to say, if you have a small child, three months old, which only weighs about seven pounds, and another of the same age which weighs ten or twelve pounds, the difference in the size of the two stomachs is practically *nil*. It does not follow because a child is small that it is less capable of taking the average meal than a well developed child.

I want to draw your attention next to the symptoms which show that a child is assimilating its nourishment well, and that what it does take is sufficient. Such a child practically sleeps the clock round, waking up for its food at intervals, but quickly going off again during the first few weeks of its existence, with comparatively little crying, and its sleep is peaceful.

As it grows older it remains awake, happy and lively, for an increasing time after its meals, but most of its life should be spent in sleep. There is no better test than the steady increase in weight. A new-born child should weigh seven to eight or nine pounds, but at first it loses weight from the discharge of the meconium. At the end of the first week it is lighter than it was when it was born, but at the end of a fortnight it ought to regain the weight at birth, and then there ought to be a steady increase. During the first six months you generally reckon a child to increase seven ounces in weight each week. Assuming that a child weighs seven pounds to start with, at the end of six months it should double, and at the end of a year treble in weight. The increase in the second six months of life should be about five ounces a week. The least disturbance in digestion will stop the steady rise in weight. If a child has an attack of constipation, of slight catarrh, or of diarrhœa, the weight for that week will remain constant, or even diminish, whereas if a child steadily increases in weight, it is certainly digesting its food well.

Supposing, on the other hand, that digestion is not going on satisfactorily, the weight, of course, will be one indication, but also the child's rest is disturbed. It is constantly waking up and crying, very fretful during the day, and often keeping the household awake half the night; sometimes because it has not had sufficient nourishment, but more often because the nourishment has disagreed and set up colic.

One interesting observation has been made with regard to the temperature soon after birth. If a baby during the first few days has a temperature of 100° to 103°, it is generally an indication that it is not having sufficient nourishment. If a young infant has sufficient nourishment, its temperature is very nearly normal. One indication, then, during the first few days of life, of the necessity of altering the food in some way, is a rise of temperature. When you find a child takes half an hour or more each time at the breast, and then gives up because it is tired out, you may be quite certain that the milk is either insufficient in quality or quantity. A healthy child will suck and get all it requires in ten minutes or a quarter of an hour at the outside, and an unduly long period means some defect in the milk. When the child is not having sufficient nourishment in the day, it wakes up and cries for its food long before it is due.

A normal healthy child, when awake, is constantly full of movement and always happy. But if a child is listless, and does not take any interest in its surroundings, and more particularly if towards the end of the first year it is unable to sit up, and the evolution of the teeth is delayed, this is an indication that the child is not properly fed. The symptoms of rickets become most marked during the second year and the cause of rickets is almost entirely defective feeding.

The condition of the fæces has to be considered. Normally a child should have two or three motions in the day consisting of pulpy, more or less uniform, yellowish, semi-solid material which ought not to be offensive, which ought not to contain undigested food, nor mucus, nor should its consistency be hard. Dry, hard motions, with constipation, are, as commonly as diarrhœa, evidence of indigestion or imperfectly selected food Generally a child with unhealthy motions, is constantly having colic; and sometimes it also has convulsions.

	Cow's milk.	Human milk.
S. G.	1028	1031 (1028–32).
Proteid ...	4 per cent.	1·5 per cent.
Fat ...	3·5 „	4 „
Carbohydrate	4·3 „	7 „

The proteids consist of caseinogen and lactalbumen, and the former greatly predominates in cow's milk forming three-fourths of the proteid, while in human milk it forms only one-third, so that the amount of curd is one-fifth that in cow's milk.

Defects in the milk.—It is difficult to be certain as to the amount of proteids in any specimen of milk, as they are not readily estimated. But the above may be accepted as an average analysis. The average amount of proteids in human milk is about 1·5 per cent., fat 4 per cent., carbohydrate 7 per cent. Whereas in cow's milk you have very much more proteid, about the same amount of fat, and very much less sugar. The proteid in human milk may vary from 1 to 3 per cent. and even run up to 4 or 5. But when the proteid amounts to 3, 4, or 5 per cent., the milk almost always disagrees with the child.

The fats do not vary very much except in very poor milk. Practically the limits are from about 3 to 5 per cent.

The carbohydrates are very constant under all conditions; they practically vary hardly at all. There is no form of medicinal treatment or exercise which in any way affects their percentage. Therefore any treatment that you

adopt is with a view to altering the proportions of the proteids and fats.

It is quite easy to examine a specimen of milk, whether human or bovine, in order to determine whether it is abnormal in some of its constituents. The proteids are difficult to estimate directly, but it is sufficient for clinical purposes to take the S. G. and to determine the amount of fat, and from these two to estimate whether the proteids are in excess or the reverse.

After the child has sucked about a third of a feed, one or two ounces of milk should be drawn off with a breast pump, and the S. G. taken with a small hydrometer. The fat can be estimated by standing the milk in a graduated stoppered tall glass tube, holding 10 c.c. at a temperature of 70° F. for twenty-four hours, and reading off the percentage of cream, three parts of fat being equivalent to five of cream; or the cream can readily be determined by the excellent small hand centrifuges now supplied by Messrs. Beck, at four guineas, used for the examination of urine and blood.

The proteid may be estimated as follows: taking as the average a milk with S. G. 1031 and 7 per cent. cream (*i.e.* $\frac{5}{3}$ of the fat), the proteids will be 1·5 per cent. The proteid will still be about normal with S. G. 1028–30 if cream is 8–12 per cent., and with S. G. 1032 if cream is 5–6 per cent., but not otherwise, because the proteids increase and the fats decrease the S. G. of the milk. Hence an excess of cream with a low S. G. does not indicate an abnormal amount of proteids. The proteid is very deficient if the S. G. is below 1028, when the cream is below 5 per cent. The proteid is excessive in amount if the S. G. is above 1032, and also the cream above 8 per cent.

How can you alter the amount of proteids and fats in milk? Increasing the proteid in the mother's diet increases both the proteids and fats in the milk. Giving fat food does not increase the fat in milk. It often happens that a wet nurse who may have been half-starved previous to the birth of her own child, when she is engaged to nurse another child, is over-fed; and the consequence is that the milk containing an excessive amount of proteids and fats, the child is upset. It is to be obviated by cutting down the amount of food, more particularly the nitrogenous food, and making the nurse take exercise.

Supposing that the amount of proteid alone is excessive, the most potent means of reducing it, is exercise. Frequently women who are well-off, feed up and take no exercise at all when nursing; the consequence is that the proteids in the milk are increased, and the child is sick. Where the proteids are in too large amount, the child is almost always colicky, and passes hard motions which give rise to a great deal of trouble. Such a case is to be dealt with by making the patient walk two or three miles at least every day. When a child is continually being put to the breast, the amount of proteids in the milk is in excess, and hence it disagrees.

So far as diet is concerned, you may say that an increase of nitrogenous food increases both the fats and proteids; and that when the patient is starving, the fats diminish in amount much more than the proteids.

If a patient takes a large amount of liquid, the total amount of milk is greatly increased, and if the fats are very markedly deficient you will find that they may be increased by giving the mother malt, or the child may be given cream and water by the spoon, so that the amount is brought up to 2 or 3 per cent at least on the day's average.

The amount of each feed which is taken is best determined by weighing the child before and after a feed.

Occasionally the sugar is too low. It is very rare to have much defect in sugar, but sometimes a child fails to increase in weight, although it takes sufficient milk, and passes none, undigested in its motions. This is generally evidence that the amount of sugar in the milk is deficient. On the other hand, if the amount of sugar is too great, the child has colicky and green motions of an acidy, offensive smell. As a rule, these cases of defective sugar in the diet are not breast-fed, but children fed artificially.

To increase the quantity ...	Increase liquids in mother's food.
To increase the solids ...	Shorten intervals of suckling.
To decrease solids... ...	Lengthen intervals and take more exercise.
Increase fat	Increase proteids in diet.

The golden rule for the successful suckling of infants is regularity. The correct intervals should be kept to exactly, as the child appreciates accurately the right time for a feed within ten minutes. If the child is irregularly fed it will not thrive, even if every other condition be satisfied. It is desirable that every woman should suckle her infant for her own sake for a few weeks, as it greatly facilitates the sub-involution of the uterus and her own recovery of health. With a healthy, vigorous mother the child will thrive best if

suckled for six months, but under no circumstances for more than eight, and then the weaning must be carried out gradually.

Symptoms.—When the amount of fat in the milk is too high, children tend to regurgitate their food; they take the breast, and half an hour afterwards a certain amount comes back. If this is constantly happening it is generally due to the amount of milk being too rich, and practically the mother wants a diet less rich in proteids. On the other hand, where the fat is low the stools are hard and dry. This condition may also be due to an excess of proteids, when there will be colic and the stools will contain undigested curds. Where the fats are deficient, by giving cream you may to some extent obviate the defect, but excess should be avoided.

Sometimes hard motions, assuming they are not due to excessive proteids, may be obviated by putting the child on malt or a little sugar, which tend to soften the motions.

When the proteids are in excess, most commonly there are dry motions with constipation, but occasionally diarrhœa, and in any case colic with undigested curds in the motions.

You might lay down these general rules. In cases of colic a reduction of the proteids is the probable requirement. If a child vomits immediately after taking its food, it probably takes too much and must be taken away from the breast sooner, or given an ounce of water before the feed; if it regurgitates a quantity of its food an hour afterwards, it is probably having too much fat; if it has constipation, you want to increase the fat and decrease the proteids.

But in some cases you find when women take too much liquid, and particularly when they take too much alcohol, and still worse when they take too much beer, it is very difficult indeed to get a child to digest its food at all. In some of these cases, especially beer drinkers, it is almost impossible to bring up the child without a good deal of indigestion and colic, and it is very often necessary to wean it.

In many cases, sometimes from the exigencies of society, sometimes because a woman has to go out to work, and cannot feed the child regularly, and partly, in some cases, because she is very anæmic and ill-nourished, the secretion of milk becomes increasingly defective. It is then necessary to supplement or entirely replace the breast by artificial food. Supposing the amount of milk secreted is deficient, the first thing that should be done is to feed the patient better, and to ensure that she has an unbroken night's sleep. Give her malt and a certain amount of alcohol, and as a result you will very often find that a considerable increase in the secretion of milk takes place. But besides that, a great deal can be done with gentle massage of the breast for ten minutes two or three times a day, which generally increases the secretion. When a breast is imperfectly emptied, the secretion decreases, complete emptying being a great stimulus. Hence a vigorous baby will make a breast secrete more milk.

After some months of lactation the milk contains less proteid and more sugar. Still, there are some women with such bad health or so anæmic, that under no conditions will it be advisable for them to suckle. It will then be necessary to commence artificial feeding at once.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Taylor.

Mary	38.	Tubercular peritonitis and pleurisy.
	39.	Rheumatism. 3rd attack. Endocarditis.
	40.	? Typhoid.
	42.	Gastric ulcer. Thrombosis of left femoral veins.
	43.	Hemiplegia. Mitral stenosis.
	44.	? Hysteria.
	45.	Tubercular kidney. Excised.
	48.	Exophthalmic goître.
	50.	Gastric ulcer.
Philip	21.	Acute rheumatism. Pericarditis.
	23.	Right hemiplegia and aphasia.
	24.	Diabetes mellitus.
	25.	? Enterica.
	27.	*Aortic regurgitation.* Abdominal aneurysm.
	28.	? Cerebral abscess.
	29.	Mitral stenosis and regurgitation.
	32.	Phthisis and tubercular laryngitis.
	34.	Ascites.
	37.	Morbus cordis.
	40.	Double aortic disease.

Cases under Dr. Hale White.

Mary	13.	Cerebral tumour.
	14.	Acute osteo-arthritis.
	16.	Cerebral tumour.
	17.	Mitral stenosis and regurgitation. Ascites and anasarca.
	18.	Mitral stenosis and regurgitation.
	19.	Hysteria.
	20.	*Chronic constipation.*

Mary	21.	Syphilitic periostitis. Syphilitic spleen.
	22.	Gastric ulcer.
	23.	Hemiplegia. Syphilitic.
	24.	Right pleuritic effusion.
	Cot A.	Meningitis.
	Cot B.	Empyema.
Philip	1.	Acute nephritis.
	3.	Cerebral tumour.
	4.	Fibroid lung. Pulmonary-osteo-arthropathy.
	5.	Appendicitis (1st attack).
	6.	Diabetes mellitus.
	7.	Typhoid fever.
	8.	? Typhoid fever.
	9.	Acute rheumatism.
	10.	Chronic tubal nephritis. Uræmia.
	11.	Appendicitis. Operation.
	12.	Mitral regurgitation. Right pleuritic effusion.
	13.	Carcinoma of liver. ? Primary pylorus.
	14.	Tertiary syphilis.
	15.	Typhoid.
	16.	Double lobar pneumonia.
	17.	Eczema.
	18.	Epithelioma of œsophagus.
	19.	Typhoid fever.
	20.	Phthisis. Tubercular laryngitis.

Cases under Dr. Perry.

Mary	1.	Rheumatism. Pericarditis.
	2.	Pleurisy. Pericarditis. Mitral incompetence and stenosis.
	3.	Gastric ulcer.
	4.	General œdema.
	5.	Typhoid.
	6.	Carcinoma pylori.
	7.	Rheumatism. Mitral incompetence. Stenosis.
	10.	? Congenital heart disease.
	12.	Alcoholic peripheral neuritis.
Stephen	1.	Pyloric obstruction. Dilated stomach.
	2.	Nephrolithotomy.
	5.	Tuberculous peritonitis.
	6.	Rheumatism. Mitral incompetence and stenosis.
	7.	Pneumonia.
	9.	Typhoid.
	10.	Chorea. Mitral disease. Subcutaneous fibroid nodules.
	11.	Chronic bronchitis. Fibroid lung.
	13.	Sarcoma of tonsil.
	14.	Enteric.
	17.	? Septicæmia.
	18.	Growth in lung.
	20.	Hepatic carcinoma.

Cases under Dr. Bryant.

Mary	25.	Phthisis.
	26.	Mitral stenosis and regurgitation.
	27.	Empyema following on pleuritic effusion.
	28.	Mitral stenosis and regurgitation.
	32.	Hæmatemesis.
	33.	Chronic nephritis.
	35.	Gastric ulcer.
	37.	Mitral stenosis and regurgitation.
Stephen	21.	Pleurisy.
	22.	Mitral stenosis and regurgitation.
	23.	Rheumatism.
	25.	Enterica.
	26.	Pneumonia.
	29.	Sarcoma of lung. Secondary.
	30.	Chronic nephritis. Pleuritic effusion.
	33.	Pleurisy.
	35.	Appendicitis.
	36.	Peleosis rheumatica.
	37.	Cyanosis. ? Thrombosis vena cava. ? Mediastinal growth.
	39.	? Carcinoma of stomach.
	40.	Acute rheumatism.

In the Surgical Wards.

Cases under Mr. Howse.

Job	21.	Tuberculous arthritis of hip.
	23.	Epithelioma of penis.
	24.	Enlarged prostate.
Lydia	1.	Tumour of breast. ? Carcinoma.
	2.	Talipes valgus. Rheumatic arthritis.
	15.	Tuberculous cervical adenitis.
	16.	Varicose veins.

Cases under Mr. Lucas.

Astley-Cooper	1.	Dislocation of acromio-clavicular joint.
	12.	Fracture of os calcis.
	17.	Compound fracture of femur.
Lazarus	15.	? Renal calculus.
	17.	Recurrent epithelioma of cervical glands.
	19.	Reducible inguinal hernia.
	21.	Ulnar paralysis (old injury).
Martha.	9.	? Renal calculus.
	16.	Granuloma of jaw. Caries of tooth.
	22.	Reducible inguinal hernia.
	24.	Sarcoma of leg.
	Cot A.	Cleft palate. Hare-lip.

Cases under Mr. Golding-Bird.

Charity	3.	Tuberculous elbow. Excised.
	8.	Movable kidney.
	17.	Tuberculous cervical adenitis.
	Cot B.	Tuberculous knee-joint.
Cornelius	1.	Divided tendons of thumb. Sutured.
	13.	Fractured ribs. ? Fractured base of skull.
	14.	Concussion.
	16.	Compound fracture of tibia and fibula.

Luke	7.	Vesical calculus. Litholapaxy. Suprapubic cystotomy.
	12.	Chronic intestinal obstruction. Colotomy.
	14.	Recurrent carcinoma of superior maxilla. Excised.

Cases under Mr. Jacobson.

Dorcas	1.	Otitis media.
	8.	Necrosis of femur. Sequestrotomy.
Cot B.		Cleft palate.
Naaman	6.	Leucoplakia. ? Epithelioma of tongue.
	11.	Stricture of urethra.

Cases under Mr. Symonds.

Job	14.	Epithelioma of tongue. Excised.
	15.	*Osteo-arthritis. Loose bodies in knee-joint.*
Lydia	19.	Trigeminal neuralgia. Neurotomy of trunk of fifth nerve.
	20.	Osteo-arthritis. Irreducible inguinal hernia.
Samaritan	8.	Suppurating hæmatoma.

Case under Mr. Lane.

Martha	1.	Tuberculous ganglia of wrist and finger.

Cases under Mr. Dunn.

Luke	3.	Hæmorrhoids. Excision.
	4.	Reducible inguinal hernia. Radical operation.
Charity	Cot D.	Double alveolar hare-lip. Cleft palate.
Patience	5.	Alveolar abscess.

Cases under Mr. Fripp.

Dorcas	19.	Tuberculous cervical adenitis. Excised.
	19.	Movable kidney.
Naaman	22.	Epithelioma of cheek. Excised.
Patience	15.	Mammary abscess.

Chapel News.

The first of the series of winter lectures for the students and staff will be given *in the Court Room* on Thursday next, November 15th, at 12.30 p.m. The Bishop of Rochester, as Chaplain of the Hospital, has kindly consented to be the lecturer.

It is hoped that the change of time (12.30 instead of 5 o'clock) will suit the convenience of those who wish to attend.

The other four lectures will be in the chapel. They have been arranged as follows:—

December 6th ...	... The Bishop of Stepney.
January 24th, 1901 ...	Canon S. M. Taylor.
February 14th „	... Canon Newbolt.
March 14th „	... Canon Gore.

The Scale of Fahrenheit's Thermometer.

My best endeavours made for many years have altogether failed in obtaining an authentic account or reason as to the principle on which Fahrenheit constructed his well-known scale, which is now universally used in England. No mention of its meaning is to be found in any work of natural philosophy or chemistry with which I am acquainted, and I have not yet met with a professor (and I have interrogated some of the most distinguished) who could give me any information about it. Most of them admitted that they were quite ignorant of its origin, and two surmised that the number 180, marking the degree between freezing and boiling, had something to do with the half circle. My friend Mr. Stromeyer, an engineer, *told me some time ago that he believed the* scale was made from the temperature of the blood, and probably this information was gained from the *Encyclopædia Britannica*, to which I shall presently refer.

I should have taken no further trouble in the matter had not my interest in it been again revived by reading a paper in the *Philosophical Transactions* for the year 1701, in which it is proposed to make a thermometer founded on the temperature of the human body. The paper is anonymous, but I believe it is the opinion of Lord Kelvin that it was written by no less a man than Sir Isaac Newton.

The paper in the *Philosophical Transactions* supposed to be written by Newton is to be found in vol. xxii., p. 824, April, 1701. It is written in Latin, and entitled *Scala Graduum Caloris*. The following are the portions which I quote.

> In hujus tabulæ columna prima habentur gradus caloris in proportione arithmetica computum inchoando a calore quo aqua incipit gelu rigescere tanquam ab infimo caloris gradu seu commune termino caloris et frigoris, et ponendo calorem externum corporis humani esse partium duodecim.
>
> Patet autem per hanc tabulam quod calor aquæ bullentis sit fere triplo major quam calor corporis humani.
>
> Ex his inventis ponendo calores olei ipsius rarefactione proportionales et pro calore corporis humani scribendo partes 12 prodiit calor aquæ ubi incipit bullire partium 33.

Before this time thermometers had been made by Hooke and others, but found to be of little value. Newton (if he be the author) used linseed oil in a glass tube, and in his paper he gives a table showing the *height on this instrument at which different liquids* boiled, saying, "In the first column we have that degree in which water begins to freeze as the lowest degree, and making the external heat of a human body 12 degrees. Now it appears that the heat of boiling water is almost three times greater than the heat of the human body, being 34 degrees." I might remark that the duodecimal system was then in universal use, and therefore Newton,

wishing to make the temperature of the body in accordance with this, he marks it 12, leaving room for the higher temperatures, zero being freezing point.

A few years after the publication of this paper Fahrenheit made his thermometer, and followed Newton by making the temperature of the body his first resting place, counting upwards and downwards from this fixed point. Whether he knew of Newton's essay I am not aware, but in all probability he did. He found he could get a greater cold than that of freezing water by mixing together ice and salt. This point, therefore, he made his zero. He thought also that it would be better if he enlarged the scale by doubling the numbers, and making that of the body 24 instead of 12, starting of course from his own zero. This made the freezing point 8 and the boiling point 53, which, as his predecessor had said, was about three times that of the human body. His scale then stood thus: Zero that of ice and salt mixed, 8° for freezing, 24° for the human body, and 53° for boiling. He then further extended the scale by dividing each degree into four parts, so if it is multiplied by four we have the scale now in use, 32° for freezing, 96° for the body, and 212° for boiling. In this way the thermometer seems to have been evolved. Subsequently these degrees were still found to be too large for accurate measurement, and so were divided into ten parts each, This is a modern innovation, for the decimal system did not come into vogue for many years after Fahrenheit's time.

This information is gained from the *Encyclopædia Britannica*, and I apprehend that the writer of the article must have obtained it from authentic sources—from the writings of Fahrenheit himself or from some of his contemporaries. His thermometer, which I always regarded as an abomination, is now looked upon by me with a great and two-fold interest. Its scale being founded on the temperature of the body, and this naturally under the duodecimal system receiving the round number 12, became the point from which every other number proceeded. The paper does not state how the temperature of the body was ascertained; possibly in various ways, which accounts for the figures being not quite accurate, and not in accordance with the fixed figure on our modern instrument; Newton, however, is careful to say the "external" heat of the body.

Some amount of doubt must still remain as to the explanation of the scale which I have given, seeing that no mention of its origin is to be found in scientific books, and the account given in Brande's *Dictionary of Chemistry* is of a totally different kind, although the author of the article hesitates in attributing it to Fahrenheit. It is said therein "that the 180° between freezing and boiling was chosen by Fahrenheit—or probably Réaumur—for some of his experiments on the expansion of mercury. When he plunged his thermometer into melting snow, the 11·156 parts of mercury which it contained expanded when placed in boiling water to 11·226, being an increase of 180 parts." This is said to be the origin of Fahrenheit's scale, the constructor carrying it still lower when he found he could obtain a greater degree of cold. In this account it is not stated why he used this amount of mercury, and therefore it can only be inferred that it was the quantity contained in the bulb. It is difficult to understand how a scientific man could have adopted so arbitrary a method, and therefore probably the description is incomplete. It may be remarked that Newton experimented in the same way, and his results are mentioned in the paper referred to; he there showed the increased space which 1,000 parts of oil occupied when raised to the temperature of the human body or that of boiling water.

I should like to say that I am inclined to put full credence in the account I have taken from the *Encyclopædia Britannica* as to the origin of Fahrenheit's thermometer, and although I know that sentiment should have no place in a scientific investigation, I cannot but hope that it is correct, for I must admit that to a certain extent "my wish is father to the thought." For the future, whenever I see a thermometer in use to mark the temperature of the body, I shall be reminded that it was first used for this purpose in order to mark the starting point of the scale from which all other temperatures were to be reckoned. At the same time there will be the pleasing remembrance that it was our great Newton who, in all probability, suggested the temperature of the body as the starting or determinate point in the thermometer, and marking it by the round number 12.

SAMUEL WILKS.

(Since writing the above I have had recalled to my memory the paper by Dr. Stevenson in *Guy's Hospital Reports* for 1880. He there states that Fahrenheit made his fixed point the temperature of the human body. This is confirmatory of my statement and I shall now look upon the fact as established.—S. W.)

Pass List.

Final Conjoint Examination, October, 1900.

MEDICINE, SURGERY AND MIDWIFERY.—*S. Hodgson, *F. W. Sime, *L. E. Stamm.

MEDICINE AND SURGERY.—*C. E. Hicks, *G. Lewin.

MEDICINE AND MIDWIFERY.—*P. W. L. Camps, *D. Forsyth, J. A. B. Hammond, *H. McD. Parrott.

SURGERY AND MIDWIFERY.—*J. A. Butler, H. S. French, J. F. Robinson, D. W. Smith, N. F. Ticehurst.

MEDICINE ONLY.—*F. G. Gibson, *J. S. Steele Perkins, G. Shorland, *W. M. Thomas, *T. J. Wright.

SURGERY ONLY.—E. C. Bevers, *H. Braund, F. Curtis, *E. H. Felton, *K. W. Goadby, K. V. Trubshaw, G. T. Willan.

MIDWIFERY ONLY.—T. R. Beale-Browne, T. B. Fawley, L. Hirsch, W. Johnson, S. S. H. Shannon, F. W. Smith, E. Stott.

*Denotes completion of the Final Conjoint Examinations.

Letters from the Front.

Government Buildings,
Pretoria,
September 1st, 1900.

. . . . . Sir Alfred Milner sent for me on July 31st, to ask me if I would come up here to look after sanitary matters, and I left Cape Town at nine hours' notice.

I had an interesting journey. De Wet, good man, had been carrying out extensive alterations, and, in his opinion, improvements, in the newly-acquired Government line between Kroonstadt and Vereeniging. This delayed me one day in Bloemfontein.

I saw four wrecked trains between Kroonstadt and Viljoen's Drift, one still smoking. We had an armoured train in advance, but did not see any Boers. There were any number of dead horses and oxen, several burned farmhouses, great fragments of shell, and, alas! several English graves.

I saw Lieut. Cordua brought before the Court. He pleaded guilty, but was advised by the president to withdraw, as otherwise only one course was open for the Court. He did so, was most fairly tried, and shot in the back, and serve him right.

Even now the Boers are not satisfied, and say the plot was got up by the police. The beggars think the English Government is like their own corrupt little Republic. I am busy all day, and have little material with which to do my work. Bricks, mortar, cement, horses, mules, oxen and carts are at a premium. The military, very properly, take everything. I managed with great difficulty to get an order for the transport of 400 sanitary pails from Durban to Pretoria. When the trucks arrived they were loaded up with rails. I did not write the telegram, so am not answerable. You may fancy my state of mind. When last I passed through Deelfontein, Washbourn was ill in bed, and I did not see him, though I had wired.

Just before coming here I had spent five weeks in Griqualand, W., and Bechuanaland, visiting Barkly West, Klipdam, Tong, Vryburg and Matito, in the neighbourhood of Kuruman.

I had six days in a wagon, ten oxen to the span, and in four days covered 120 miles, which was not bad. I was investigating malaria, which does not usually prevail in this particular district. Should the fever reappear next season, the district surgeon, whoever he may be, will meet with any number of thecal abscesses; he will probably write a paper showing that they are epidemic, contagious or infectious. I pricked the niggers' fingers to obtain blood, and they are sure to do so themselves when next they have fever, using a dirty thumb or a rusty nail. They are as imitative as monkeys. We used to cut the hair on the tails of oxen square, when we inoculated a herd during the rinderpest, in order to distinguish those we had already injected. The Kaffir doctors invariably cut the hair even when they had only one animal to deal with; they thought it was the most important part of the process.

Not a Boer was on a farm in Bechuanaland. They had behaved like brutes during the occupation of Klipdam and Barkly West, and they scooted as soon as Kimberley was relieved. There was a little interregnum before the British police started to work. John Kaffir rose to the occasion; he visited those farms and left nothing but the walls and the roof.

He is now reclining with a rotund belly and a happy smile, on an iron bedstead in his hut. There are only a few goats in his kraal, but if I passed one herd of 400 or 500 in the mountains I passed four or five, guarded by little niggers, who also were in good case. I don't think the Boers will find those bucks. I hope not.

I took an opportunity of inspecting Vryburg Jail. In almost the first cell I saw Mr. Hassfather, late of the Legislative Council. When last I had seen him I was smoking and drinking whisky and soda with him in Abot's stoep at Geluck. I said, "Sorry to see you here, Mr. Hassfather." He swore he was innocent; had never left his farm or had a Mauser in his hand. Then he remarked, "Ah, when I used to inspect this place as M.L.C. I little thought I should ever live in it." To which I replied, "Then if there is anything wrong you will know whom to blame." The contractor who had built the "tronk" was also accommodated, and made a precisely similar observation, and got the same answer. The Predikant, too, was one of the happy family. The place was full of the scoundrels.

I may be able to send you some copy about sanitary matters here later, but I didn't care to write anything serious for publication just at present. The atmosphere is a trifle sultry.

GEORGE TURNER.

Fort Tuli,
Rhodesia,
September, 1900.

I left Southampton in the "Bavarian," a transport of over 10,000 tons, for the Cape, with five other medical officers, to join the Rhodesian Field Force, and on the way out there was considerable speculation as to how we were to reach Rhodesia, but when we got to the Cape it was clear that we could not go *via* Mafeking, so we were sent on to Beira after waiting five days at Durban. Whilst at Durban we had a chance of seeing Colenso and Ladysmith, so we got a pass from the military authorities, but we did not go on to Ladysmith, as Colenso, Fort Wylie and Pieter's Hill, where poor Onraët was killed, were so full of interest that our leave was spent before Ladysmith was reached.

We left Durban with the Canadian Royal Field Artillery (which joined Plumer and was at the relief of Mafeking), and arrived at Beira, April 21st. There we found several transports with bushmen and rough riders from Australia and New Zealand, waiting to be disembarked.

After landing, the men and horses suffered a great deal from sickness. The majority of the men (some 4,000) had either malarial fever or dysentery, and the horses suffered very severely from horse-sickness, a very large number dying.

Whilst at Bamboo Creek, some 60 miles from Beira, the only fresh meat obtainable was that which we shot ourselves, such as harte-beeste, wilde-beeste, zebra (not good), wart hog, etc. Game is very plentiful round there, and I saw two lions whilst out in the bush at the back of the camp, but having only my revolver with me I was not sorry when they bounded away.

From Bamboo Creek I went up to Marandellas, a distance of over 300 miles and a rise of over 5,000 feet, on to the Rhodesian plateau, and stayed there a month as junior M.O. at the hospital, and found that the "fever" was different to that down on the Pungwe flats, more "shakes" and less of the "typho-malarial" type.

From Marandellas we took the road to Bulawayo, a distance of over 300 miles, which was covered in 17 days. From Bulawayo we turned to Mafeking, getting there in July, and spent a very interesting three days, seeing all the trenches and other points of interest. From Mafeking we twice went out into the Transvaal to Zeerust—the first time to relieve the Elands River garrison, but were not strong enough, and on the second occasion to Buffelohoek, some 25 miles from Mafeking, where we lost five men killed and some 30 wounded. On returning to Mafeking the second time we were ordered back to Tuli, in Rhodesia, *via* Palapye, and from this place, which is Khama's chief town, we "trekked" to our destination, a distance of 170 miles, most of the way through a forest of small trees. The water on the trip was very bad and scarce, and during the last two days the cattle had not any water at all. On reaching the Shashi River at Tuli, it was an extraordinary sight to see the oxen and mules, after out-spanning, make a rush for the river.

Whilst at Bulawayo I met H. A. Moffat, an old Guy's man whom I knew very well. He had been with Plumer till last January, when he was invalided back to Bulawayo after enteric.

We found that the dysentery did very well with ʒi. doses of Mag. Sulph., or better still, Sod. Sulph., and also ʒss. doses of Liq. Hyd. Perchlor. every four hours. We had several cases of malarial coma, which does best by purging with Croton Oil mii.

The bullet wounds did very well. Three men shot through the lungs got well in a very few days; one man who was shot in right axilla—the bullet passing out at his left groin—had no symptoms and made a good recovery; one shot through left kidney passed blood in his urine, but afterwards did very well; an officer shot through stomach died 14 days after from profuse hæmorrhage from the rectum, caused by an abscess which had formed behind his stomach, and had opened into large intestine, involving the arterial supply. Although we found empty Martini-Henry cartridge cases after the fight, we saw no wounds from the M.-H. bullet.

From here we expect to go on to Petersburg, in the Transvaal, 270 miles away, when the Limpopo has been pontooned.

HERBERT CARDIN,
Surg.-Lieut. R.F.F.

Guy's Hospital Dental Society.

Presidential Address delivered by Mr. J. LEWIN PAYNE, on Friday, October 12th, 1900.

GENTLEMEN.—Following the custom of this and kindred societies, it falls to my lot as President to address a few words to you at this the opening meeting of our session. Allow me first of all to thank you most sincerely for the great honour you have done me in electing me to this office for the ensuing year. It is an honour which I value very highly, though I do not feel a worthy recipient of such a distinction, and especially so when I call to mind the many illustrious men who have preceded me in this chair.

Knowing, however, gentlemen, your generosity in over looking the deficiencies of one who endeavours to do his best, it is a great pleasure to me to accept the office, and I trust that, notwithstanding the shortcomings of your chairman, the present session (which unites the last year of the nineteenth to the first year of the twentieth century) may not be lacking in regard to the amount of interest shown by its members in the reading and discussion of papers and in the bringing forward of casual communications.

In addressing you to-day I should like to refer briefly to some of the responsibilities which will fall to the lot of most—I trust, all of you. I refer to the duties which the dental practitioner owes to the public at large.

The average dental practitioner of to-day holds a very different position from that which he had a quarter of a century ago. Our profession is distinctly a progressive one. The number of dental surgeons is not only rapidly increasing, but the class of work done by them is vastly superior to what it was.

Up to the year 1878 our ranks were open to the worthy and to the unworthy, to the competent and incompetent alike. Men who understood little or nothing of the anatomy and physiology of the mouth were allowed to operate upon patients, and by their failures often brought discredit not only upon themselves, but also to some extent upon others who were well qualified to practise.

In the years that are passed the question of examinations was not the all-important one it is now. A man was able to step into the ranks of dental surgeons without troubling about these. But now, however, it has become necessary for the student of dental surgery to go through a course of training which year by year is becoming more exacting and demanding more attention on his part.

Thorough education has become essential, and this in itself is wholesome for the profession which, I am sure, we all wish to honour and develope.

First and foremost, then, it is the duty of the student to fit himself for the important work which lies before him to the very best of his ability. No care should be considered too great, no trouble counted too wearisome.

With education the dental surgeon's responsibilities to his patients have correspondingly increased. Knowing what is right and best for them, his duty will therefore be a more trying one. Whoever the patient may be, whether he be rich or poor, the dental practitioner should always give his best.

Although we may vary the material for the filling, the fee should have no influence upon the quality or the conscientiousness with which the operation is performed.

By this I do not mean to imply that the methods of treatment adopted for rich and poor can always be identical. But I do want you to feel that it should be considered just as immoral to insert slipshod fillings because your patient can only afford a small fee, as it would be to attempt to extract a tooth roughly or clumsily on account of the patient being a hospital one. Our unwavering aim should be always to produce *our best*, and although, of course, every man finds that at some periods he is able to do better work than at others, a dental surgeon should feel it his duty to strive after perfection in treating every patient.

Then, again, it is incumbent upon the dentist to be scrupulously clean in all his work. He should consider it almost criminal to insert a septic instrument into a patient's mouth. His forceps, especially, should never be used a second time until they have been sterilized by boiling. As a humane operator he will also seek to reduce to a minimum the necessary pain which accompanies so many of his operations.

There are, however, many other duties falling to the lot of a dental surgeon which are hardly less important. I would especially refer to his duty in educating the people on his professional position.

The general public are, to a large extent, still liable to regard the dentist in the light of a tradesman, and I fear that the dealings of some men with their patients has been such as to lead them to think thus. We may safely say that most people, too, have no idea of the importance and the value of a tooth. There is, therefore, the necessity of educating the public in general, and your patients in particular, with regard to this matter. How ignorant the public are may be judged from two cases of misguided charity which were recently quoted in the *British Dental Journal*.

In one instance, a clergyman in Oxford, has become famous for his skill in extracting teeth. He has taken out thousands of teeth without accepting any fee. He was always willing to remove his parishoners' teeth when the slightest pain occurred, and would travel long distances in order to accomplish this end.

In another case, a minister who kept a strict record of the teeth he removed gratuitously, estimated that in twenty-five years he had extracted twenty-five thousand teeth, or, on an average, about three teeth for every day.

These gentlemen had, no doubt, the very best intentions, and though in some cases they were robbing their parishioners of some of their most valuable possessions, they thought they were doing benevolent work.

Passing from the opinions of the general public to those of the government authorities—here again we find distorted ideas with regard to the teeth. The regulations made for both army and navy recruits are far behind the times.

At the War Office a loss of ten teeth is a disqualification for a man entering, and yet after he has once been admitted no provision whatever is made to keep his teeth in good order. The conditions are absurd in contrast. In the first place, experience is more and more teaching us that in over-crowded mouths it is good practice to remove teeth that may be practically sound. They have also yet to learn that men whose teeth are inferior may, notwithstanding, have sound constitutions, and that if the deficiencies are made good by the work of the dental surgeon they may become capable and even valuable servants in Her Majesty's forces.

Considering the difficulty in maintaining an efficient army and navy it is a great pity that such arbitrary rules exist. The point we must impress is this:—Do not lower the stamina of the men, but remember that in the majority of cases dental defects can be remedied.

But before concluding I want to bring my remarks nearer home. Ignorance in regard to the teeth has not, I regret, been confined to the public at large, or even to fossilized regulations made by the government. It has sometimes been exhibited by hospital committees, and even by members of the medical and surgical profession. How often do we find in some of the large hospitals of London a surgeon operating, with all the care and precautions which modern aseptic surgery has taught, as far as the operation itself is concerned, but at the same time assisted by a house-surgeon and dressers whose mouths are simply crowded with micro-organisms arising from carious teeth and suppurating pulps, and yet surprise is expressed when the wound does not heal by primary union.

The mouths of nurses, too, in many hospitals are no better. Teeth with large cavities may be seen, septic roots lying useless in the mouth, or still worse, under the cover of an ill-fitting denture. Indeed, in some hospitals, nurses are constantly being invalided for neuralgia, alveolar abscess, and other ill-health not unconnected with the condition of the teeth. I am glad to say that these remarks do not apply to this hospital, since the authorities have taken the matter in hand, and the nurses' mouths are now inspected periodically.

I have mentioned some of the duties to which a dental surgeon is called, and you will see that not the least important is that of spreading abroad the elementary facts concerning the teeth and their disease.

In conclusion, I would say that if we desire to take our place side by side with the other great professions, it will be by the scientific work we achieve that we shall be judged and rewarded. This work must be prosecuted, too, with untiring and increasing energy. We have yet to discover how to prevent the most prevalent disease of the human race, *i.e.*, Dental Caries.

You may think it would be an unhappy day for dental surgeons if such a discovery were made, but believe me, it would no more do away with our occupation than the marvellous unveilings in the medical and surgical world have done away with the need for medical practitioners.

In closing, gentlemen, I would cordially thank you for the patient attention you have granted me, and ask you to forgive me if I have unduly wearied you, and would sincerely express the hope that the session upon which we have now entered may be amongst the most interesting and most valuable which the Guy's Hospital Dental Society has experienced.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

South African Memorial Fund.

DEAR SIR,—I have been watching each GAZETTE for some development of the suggestion to perpetuate the memory of Guy's men lost in South Africa, and am happy to send a contribution. The kindly, genial face of Tom Jones is still fresh in my memory, though I had not seen him since we left the hospital, and it is his service to our country which I should specially wish to commemorate. You ask for opinions as to the site of any tablet—my idea would be strongly *against the Chapel*, and chiefly because I cannot think it would *there* be sufficiently before the notice of the general run of men. With every wish for the success of your fund,—Believe me, yours truly, W. A. E. WALLER.

Colonsay, Rugby, 31st October.

DEAR SIR,—I have just received your appeal for funds towards placing a memorial to the Guy's men who fell in South Africa, in some part of the hospital precincts. Such a scheme will have, I am sure, the most generous support of all Guy's men, but the greatest difficulty will doubtless lie in making choice of a suitable form and position for the memorial to take.

Whilst dining in the hall on Saturday last the idea occurred to me, why not put a suitable stained glass window in the Dining Hall as a memorial to the Guy's men who fell in South Africa.

The window which one naturally selects is the one between the fireplaces with the semi-circular top. This is a large window and would perhaps cost a considerable sum, but the amount of stained glass inserted would be determined by the amount of money collected.

It would be seen by all Guy's men daily, and might lead to a more comprehensive scheme of re-glazing the whole room, somewhat after the manner of the halls in Oxford and Cambridge and many of the public schools, to other Guy's men, since doubtless there will be many men in the future whose names and deeds we shall rejoice to perpetuate.

Lastly, "The golden sunset deepens in the west." The lengthening rays of the summer's sun will light up this window and cast its reflection on us, as if to encourage us to yield our lives as willingly as they have done for the service of the common good.—I remain, yours truly,

ARTHUR W. ORMOND,
Hon. Sec. Students' Club.

22, St. Thomas's Street,
London Bridge, S.E.
November 7th, 1900.

SIR,—I shall have much pleasure in subscribing to the South African Memorial, but only on the understanding that the memorial *shall not take any utilitarian form*, and shall be placed in position accessible to *all comers* to the Hospital, preferably the Medical School Buildings or the Park.—Yours truly,

LAURENCE H. McGAVIN.

14, Sheffield Gardens, Kensington, W.
November 7th, 1900.

DEAR MR. EDITOR,—I quite agree that something should be done to keep green the memory of those who have fallen in South Africa. For my own part, I cannot see that anything could be more suitable than that a granite column should be erected in the Park, where it will be seen by and attract the attention of everybody.—I am, yours, etc., A. C. L.

Guy's Hospital, Nov. 7th, 1900.

Fat.

DEAR SIR,—The following is the history of a patient in Stephen who weighs just under sixteen stone:—Mother's maximum weight, 28st.; father weighed 17st. on the day he was married. There were 14 children; three only are still living. Patient gives the following history of his relatives:—

1 brother fell off a ladder and died; he weighed 14st.
1 brother died of dropsy; he weighed 27 st.
1 brother was drowned at sea; he weighed 26st.
1 brother died of "overgrowth"; he weighed 26st.
1 brother went to Australia and disappeared. He was the biggest of the family at the time. Two sisters are not very big—about 10 or 11 stone each.

Personal history.—Forty years ago patient was married. He has been to sea ever since.

M. C. W. (Ward Clerk).

Passim.

In another column of this issue we publish a preliminary list of subscribers to the memorial which is to be erected to the memory of the Guy's men who have fallen in South Africa. We also publish some correspondence on the subject, and may, perhaps, here take the opportunity of inviting further letters on the nature and scope of the monument. It seems to be generally conceded among the present Guy's men, if the current of general conversation can be allowed to give any indication of the trend of general opinion, that some simple tablet or brass should be placed in the Chapel at any rate, even if the bulk of the funds were employed in a different manner. There can be little doubt that our Chapel is by no means the familiar spot that those whose acquaintance ceases with School and College Chapels would imagine. Most men are only at the hospital on Sundays through stress of circumstances, and those whose appointments keep them in residence at all times find that the hours of service must perforce be utilized for the performance of their several duties. It is true that one naturally looks for memorials in a chapel, but the number of tablets already erected in the Museum shows that the seclusion of the Chapel has long been recognised. The whole spirit of a memorial to men who have fallen in their devotion to duty demands that such a memorial should be before us all in every working day of our lives. It must stand as a perpetual and insistent reminder of what Guy's men have done, and what Guy's men are expected to do.

Again, it is generally expressed that the memorial must be a memorial pure and simple, and that no factor of utility must be allowed to find a place in the scheme. This at once puts out of court any suggestion of endowment of a cot or bed, and although every Guy's man rejoices in every action which tends to lessen our financial embarrassment, yet we cannot help thinking that in the present instance an endowment fund would be in the highest degree unsuitable. If it were only for the fact that this would at once remove the memorial from the sphere of the three hundred or so who are not working in the wards, we should consider such a scheme undesirable, but when it is considered that the memorial would then merge into one of many, commemorating a diversity of names and actions, the idea becomes absolutely untenable. It remains, therefore, for subscribers to decide upon the site and nature of the memorial, with the restricting clause that the monument be permanent, pure, and central. To this end we can do no better than repeat our request for correspondence on the subject, and we might suggest that a cheque could be enclosed in the same cover.

The Annual Smoking Concert will be held on Saturday, November 17th. Following the precedent of last year, the Residents have decided, and we think with much wisdom, that the average man would rather pay for a ticket and obtain an excellent evening's entertainment than sit out a gratuitous exposition of the doubtful talents of his musical colleagues. The old idea that anything was good enough for a smoker is now exploded, and with the appreciation of this fact comes the necessary corollary that all good things have their market value. The surplus monies, after the payment of necessary expenses, will be handed over to Mr. Goble's Out-patient Children's Tea Fund, an object which is deserving of all support. It is also proposed to devote the proceeds of the sale of the excellent "posters" which have been designed by Mr. Stanley Cock, and kindly presented by him for this purpose, to the same fund. We may, therefore, call the attention of intending subscribers to the notice that is exhibited in the colonnade, and urge would-be purchasers to send in their bids to the President of the Residents without delay.

Owing to the Smoking Concert falling on the date of the Physical Society's pathological evening, this and the following item in the society's programme will be dealt with a week later than the published dates. Thus the Pathological Meeting will be held on November 24th, and not on the 17th.

The "Old Crocks" gave the lie to their title by the comparative ease with which they defeated the 1st XV. at Honor Oak Park last Saturday. It seems that even four years abstinence from football does not prevent a man from playing a rattling good game when he sets his mind on it, and it also appears that even the perfection that is arrived at from practice is not always able to successfully combat the fierce onslaughts of the untrained hordes. The result of the match caused a great deal of amusement and a deal of chagrin, and if no other purpose be served, it will at least impress upon the fifteen that as a team it is capable of improvement. A return match is to

be played to-day, and the "Old Crocks" are going to try and maintain their superiority. The fifteen naturally feels that its honour is at stake and will make strenuous efforts to wipe off last week's defeat. So that between these two conflicting elements the spectator ought to arrive at a very keen and interesting afternoon's play.

ATTENTION is called to the series of lectures which are to be delivered in the hospital chapel during the succeeding winter session. The time has been changed from five o'clock to half-past twelve in order to suit the convenience of men who have to attend lectures of a different nature. The first of the series will be delivered by the Chaplain of Guy's Hospital, the Right Rev. the Lord Bishop of Rochester, and will take place in the court-room, as it is considered unlikely that the chapel will be out of the workmen's hands by that date. Other lecturers are the Bishop of Stepney, Canon Taylor, Canon Newbolt and Canon Gore.

THE Committee of the GAZETTE is making arrangements for the publication of a Christmas Card in accordance with the custom of previous years. The card will be illustrated by black-and-white designs by Mr. Murray Thomas, and will be issued as usual from the library. As soon as possible a specimen card will be on view, and intending purchasers should then give their orders to the librarian. What usually happens is that the issue is slack until just before Christmas-day, and then a big rush sets in, with the inevitable consequence that the supply is unable to meet the demand. If men will have the forethought to order early, it will be possible to form some estimation of the number to be printed, and much otherwise unavoidable disappointment will be saved.

THE Secretary of the Davies-Colley Memorial Fund wishes to call attention to the fact that the subscription list will very shortly be closed. He would be glad, therefore, if intending subscribers, and those who have already promised subscriptions, would send him their cheques with as little delay as possible.

Two general meetings of non-affiliated clubs have been held recently, and both have been credited with enthusiastic audiences. The Chess Club has had its appetite for shields and things whetted by the partial possession of that very curious trophy which hangs in the smoking-room. The club yearns for more freedom, more foes to conquer, more trophies to hoist. If anyone has ever watched a chess contest in the smoking-room, and listened to the soft purring of the pipes, broken now and again by the click of the chessmen; if he has ever heard the sudden elevation of a voice of triumph explaining how the mate was effected and how but three moves before the winner had experienced all the pangs of the vanquished—needlessly, of course—then he will sympathise with all those who yearn for advancement in the ranks of chessmen, and he will congratulate the Chess Club on its great keenness. We wish the secretary, Mr. E. H. B. Milsom, every success in his year of office and a bigger share in that castellated outrage at the end of the season.

THE other club which has passed through its annual cleansing is the Students' Glee Club. Everybody must be aware of this club by now, and everybody must at one time or another have listened to its soft wailings in the court-room. From a critical investigation of the "pieces" studied by the society it becomes painfully evident that the Glee Club is of a morose and saturnine cast of character. One associates with glee clubs the singing of merry roundelays, with laughing choruses and a proper flourishing of the wine-cup after the best traditions of comic opera; therefore, a course of farewells to forests and similar mournful ditties produces the conviction that the society has mistaken its function or at least its title. This year, at any rate, there is no reason why the music considered should not be of a more cheerful nature than heretofore. The executive must see to this not unimportant point, otherwise there will be the same conviction of wasted labour as was experienced last year, when the practices of sacred subjects died out from "deficient inherent vitality." The Nurses' Choral Society will, as usual, combine with the Glee Club in the production of four-part works, and will doubtless have as successful a season as in years past.

QUITE unintentionally we have been persistently reducing Mr. J. A. Glover, late London Scottish, to the ranks. We have been crediting him with the rank of Private in the C.I.V., while for some time he has been Quartermaster and Hon. Lieutenant in the New South Wales Medical Staff Corps. There is reason to believe that he will not be home for some three months yet, so his many friends who expected him in a few days or weeks, must consume their souls in patience a little longer.

We have to chronicle the issue of a new Students' Gazette under the guise of the *University of Durham College of Medicine Gazette*. In an explanatory editorial the editor of the U.D.C.M.G. states that the wants of the medical section of the University of Durham have long been inadequately met by the official University Journal, partly because of the geographical distribution of Durham medical students, and partly because the *Journal* was loth to publish much matter that would prove uninteresting to all save a certain small section of its readers. The first number is a highly creditable production, and we congratulate the editor upon his maiden effort. He has evidently recognised the value of a "calendar of coming events," for we find in the familiar site, beneath the "contents," a Durham version of our own calendar, and indeed, in several ways, the new comer shows that the Guy's Hospital Gazette has once more served as a model. Perhaps, though, the new journal would have done better if it had appeared in other than "crown 4to." The size is rather awkward when the completed volumes are bound and put on the shelves, and for a new comer, starting life without traditions, a more convenient size might have been chosen. Possibly the editor will forgive us if we suggest that he should adopt some species of telegraphic address or code-word for use in place of the cumbersome title given above. Also, he would do well to use "brevier" in the body of the gazette, and reserve the "long primer" for special copy. We wish the gazette every success.

An old Guy's man has written to know why the "Mess Dinner"—Guy's Hospital Auxiliaries' Mess used to be the full title—has been allowed to die out. He thinks it shows a pitiable lack of keenness among the Volunteers at Guy's that such a dinner, which served to unite all the men in the various corps, as well as men in the Navy and the R.A.M.C., at one common table, should have died out from want of initiative. We believe these dinners were always well supported and were invariably very successful. The only difficulty apparently was in the procuring of a secretary who was willing and keen enough to do the various odd jobs incidental to a function of this nature. But with the revival of volunteering, there should be no difficulty in this respect, and we sincerely hope that a sufficiently energetic man will appear and start the ball rolling. First call a meeting, then elect a committee, and the rest goes by itself. Our correspondent also issues a word of warning with regard to the various volunteer companies at the hospital. He anticipates a serious slump in volunteering, and is of opinion that existing members of corps at Guy's should attempt an early and systematic process of recruiting in order to counteract as far as possible the decline which is inevitable with the restoration of peace. No doubt his suggestions will receive attention in the proper quarters.

We have just received the news that an old and familiar figure of a few years back has joined the great majority. Mr. G. Chapman, who for many years was Clerk of the Works at Guy's Hospital, died a week ago at Milford, Surrey.

Surgery.

(*With apologies to R. K.*)

By the grand old muddy river
Looking southward t'wards the sea
There's a fearsome red-brick building
Where they plough men easily;
For the Conjoint Board is sitting,
And it's there that I would be,
Writing eager, hopeless papers
Full of novel surgery.

Come you back, you awful crock,
Come again and get the knock!
They are sitting four times yearly; oh, buck up, pull up your sock!
On the road to a degree,
Full of pinks—referred for three!
With revisions, tests and vivas, all designed to torment thee.

I had answered all their questions,
I had named their wooden knife,
And I watched the sullen river
Till I loathed my very life.
And back I went to Hades
And once more they played me tricks,
For they locked me up, then loosed me,
And referred me back for *six!*

Come you back, etc.

If they ever make me member
Of their wretched little clique,
I shall go before them smiling
With my tongue within my cheek;
For my fame has gone before me,
And I'm free from petty ills,
I have made a mighty fortune
By the sale of Windy Pills!

Come you back, etc.

With the Army Medical Corps in South Africa.

(By Our Special Correspondent.)

(Published by permission of the Director-General of the Army Medical Service.)

Wolvehoek, O.R.C.,
August 31st, 1900.

Treatment in the Field.

It may be useful for those likely to travel under similar circumstances to have a short description of the medical field equipment used in the army, and of its use. With a few minor exceptions, the former could hardly be improved.

The staple equipment consists of No. 1 and No. 2 Medical Panniers.

These are made of basket-work covered with cow-hide, and fitted inside with green baize compartments for bottles, with baskets, drawers and trays, the whole weighing respectively 91 and 72 pounds. The two together may be strapped on either side of a mule or horse for pack-transport, their combined weight being equal to that of a man weighing eleven stone nine pounds. Their dimensions are about two and a half feet by one by one. Most of the drugs are in the form of tabloids in small two-ounce bottles, about twelve dozen tabloids to a bottle. One bottle-full is sufficient for most drugs, but there are nine bottles-full of quinine, three of ipecacuanha, and several different preparations of opium. This store is about sufficient to last a battalion of 1000 men for three months, if they are engaged in no very serious action during that time, and if their more serious cases can be invalided from the battalion every few days. The contents and their use may be classified therapeutically as follows, suggested addenda being put in italics. The amounts given are those provided in each No. 1 Pannier. Where no amount is given, one small bottleful is provided.

N.B.—It will be understood that treatment in the field is only treatment of minor complaints, or of the more serious in their early stages. The conditions enumerated below, include all that the writer has seen during five months' work at the front.

A. No. 1 MEDICAL PANNIER, containing medicines and instruments.

Antiseptic Solutions.—Hyd. Perchlor tabloids (for 144 pints of 1 in 1000), Carbolic, pure liquified (for 8 pints of 1 in 20), and Boracic powder (for 3 pints). But usually the pure Carbolic and the Boracic powder provided, will be used for other purposes.

Antiseptic Powders.—Boracic (oz. 2), and Iodoform in vulcanite dredger (oz. 3).

Anæsthetics.

1. General; Chloroform ʒxvi (for about 12 operations).

2. Local; Cocaine, tabloids Hypod. gr. $\frac{1}{4}$, tubes 5 (for about 50 operations).

For Diseases of the Alimentary Tract.

1. Carious teeth (forceps in No. 2 pannier); pure Carbolic Acid, Tinct. Aconiti (tabloids to be dissolved and painted on gum); hot fomentations, especially Spongiopiline (No. 2 pannier); *Darby's Capsicum plasters.*

2. Ulcerated gums; lunar caustic (oz. 1); borax and *glycerine.*

3. Tonsillitis; Pot. Permang. gargle, tabloids gr. ij., one for a pint (2 bots.) or Garg. Hyd. Perchlor., Tinct. Aconiti, Ac. Gallic, *Pot. Chlor. et Ferri.*

4. Constipation; Pil. Col., Cal et Rhei (No. ix.), Calomel, and a Pil. Podoph. Co., containing Podoph., Hyos., Tarax., Col. Co., Jalap, and Leptandrin, Ol. Ricini (ʒxvi.).

5. Diarrhœa and colic; Ol. Ricini with Aq. Menth. Pip. as a placebo (from Ol. Menth. Pip. ʒi.), Ext. Opii, Tinct. Opii, Tinct. Chlorof. et Morph. Co., Pulv. Opii, Pulv. Ipecac. Co., Pulv. Cret. Aromat. cum Opio, Pil. Opii Camphoris et Capsicini, Lead and Opium Pill; Cal., Antim., Ipecac. cum Opio; Mist. pro diarrhœâ (a mixture of essential oils, found very useful in India).

6. Dysentery; Ol. Ricini, Ipecac. (3 botts.), *rectal irrigation, Mag. Sulph.*

7. Vomiting and poisons; Zinci. Sulph. and Apomorph. Hyd. gr. $\frac{1}{10}$ (tubes 2 pro injec.) as emetics, Atrop. Sulph. pro injec. gr. $\frac{1}{100}$ as antidote; preparations of Opium and Sodæ Bicarb. as sedatives; *gastric lavage.*

8. Dyspepsia (see to teeth and food); Sodæ Bicarb., Pot. Bicarb.; preparations of Opium; Ol. Menth. Pip.; Opium, Camph. and Capsicine Pill; *gastric lavage; bismuth.*

9. Piles (cold bathing; aperients); Gallic acid powdered and mixed with vaseline.

For Diseases of the Respiratory System.

1. Coryza; sniff up Boracic powder or Pot. Permang. solution, Pulv. Ipecac. Co., Quinine.

2. Tracheitis; Rigollot's mustard plasters (tins 2), Pulv. Ipecac. Co., Ammon. Carb. tabloids, gr. iii., *glycerine.*

3. Dry pleurisy; mustard plasters, Ol. Terebinth. as liniment, adhesive plaster for strapping, Pulv. Ipecac. Co.

For Diseases of the Circulatory System.

1. Disordered action of the heart (D.A.H., a recognised disease in the Army); Strychn. tabloids gr. $\frac{1}{100}$ pro injec., Sp. Ammon. Aromat. ʒviii., Brandy ʒxvi.

2. Varicose veins; Ol. Terebinth. as liniment, bandage or puttee for support; *suspender* (for varicocele).

For Diseases of the Uro-gen. System.

1. Gleet; Zinci Sulph. as injection (8 tabloids gr. v. to Oj.).

2. Chronic orchitis; *suspender, Iodine* for painting.

3. Stricture; olivary-headed catheters (6), nickel (1), silver (2), vesical trocar and cannula.

4. Syphilis; Iodof., Lotio Hyd. Perchlor. externally and the same (ʒiv, in die) internally; *Pot. Iod.*

5. Hydrocele; trocar and cannula, strapping, *Iodine, suspender.*

For Diseases of the Nervous System.

1. Headache (see to teeth); Aperients, Antipyrin (*and Caffeine*), Pot. Brom.

2. Insomnia; Antipyrin, Chloral Hyd., Opium, Morph. pro injec.

3. Debility; Tab. Quin. Ferri Arsen. and Strychn. (No. VI.), Blaud's pills, Strych. pro injec.; Quinine, Sp. Ammon. Aromat., Brandy ʒxvi., *Ferri and Quin. Cit.*

For Rheumatism and Lumbago.

Sod. Salicyl., Sodæ and Pot. Bicarb., tonics and Ol. Terebinth. as liniment.

For Malaria (Acute and Chronic).

Quinine (9 bots.) tabloids gr. ii. and gr. v., Quin. Hydrobrom. gr. ss. pro injec., tonics, Blaud's pills, *Ferri and Quin. Cit.*

For Diseases of the Eye.

1. External; Pulv. Ac. Bor., Hyd. Perchlor, Vaseline, lunar caustic, cocain tabloids gr. $\frac{1}{20}$, hot fomentations.

2. Internal; tabloids Atrop. Sulph. gr. $\frac{1}{200}$ (tubes 2), Cocain gr. $\frac{1}{20}$ (tubes 3), Eserin Salicyl. $\frac{1}{600}$, Homatrop. Hydrochlor. $\frac{1}{40}$, Homatrop. Hydrochlor. $\frac{1}{20}$ and Cocain gr. $\frac{1}{20}$, Morph. Hydrochlor. $\frac{1}{500}$ (tubes 2), Morph. Sulph. and Atrop. Sulph. aa. gr. $\frac{1}{500}$, with forceps and camel-hair brushes (2).

For Diseases of the Ear.

Syringe, Pulv. Ac. Bor., Hyd. Perchlor.

For External Sores ("Veld-sores," Saddle-chafe, Boot-sores, etc.).

Hyd. Perchlor. Pulv. Ac. Bor., Vaseline (small boxes 2), hot fomentations, *Hyd. Ox.* for ointment.

For Ricked Muscles, Sprains and Synovitis.

Ol. Terebinth. for liniment, *Iodine*, *Liq. Epispast.*, mustard plasters, strapping, bandages, splints (see No. 2 Pannier).

For Hæmorrhage and Pain from Wounds.

Morph. Hydrochlor. tab. gr. $\frac{1}{6}$, pro injec. (tubes 5), Morph. Hydrochlor. gr. $\frac{1}{8}$ and Atrop. gr. $\frac{1}{150}$ tab. pro injec.; warm *rectal injections*.

For Wounds, Dressings, Fractures and Food (see contents of No. 2 Pannier).

The remaining contents, instruments and appliances, of No. 1 Pannier are as follows:—

1. Hypodermic cases (2), each with 2 needles, cocaine gr. $\frac{1}{4}$ (tube 1) and morph. gr. $\frac{1}{6}$ (tube 1);

2. Case of hypodermic and ophthalmic tabloids (detailed above);

3. Tin case of tabloids and pills (9in. × 6in. × 1½in., containing small quantities of most important drugs detailed above); useful for a day or two's expedition;

4. Instrument box, enclosed in two tin trays (for use to hold lotions and instruments) containing the following metal-handled instruments:—amputating knives (6, 9 and 11 inches) 3, bistouries (1 hernia) 4, scalpels 4, saws (1 movable back) 2, scissors 1 pair, trephine, trocars and cannulas (vesical and scrotal) 2, needles (½ curved in vaseline in vulcanite case) 6, ditto for wire 12, Liston's with handle 1, aneurysm 1, forceps (Spencer-Wells 6, dissecting 2, artery 2, bone, bullet), director, elevator, probes (metal 1, bullet 1) 2, tracheotomy cannula, probang, catheters (olivary 6, nickel 1, silver 2), tourniquet, wire and pliers;

5. Sterilizer (about 1½ pints), lamps and spirit;

6. Irrigator tins 2, rubber-tubing and bone nozzles 2, pinch-cocks 2;

7. Thermometers 2, stethoscope (aluminium), tongue-depressor, test-tubes 3, and test-paper books 2;

8. Spare bottle 1, minim measures 3, vulcanite medicine-cup and mortar combined 2, pestles 2, stopper-loosener, nested gallipots 3, tea-spoons 2, camel-hair brushes 6;

9. Scissors, safety-pins (3 doz.);

10. Candle-lantern, candles 6, and wax-matches, waterproof;

11. Writing materials, viz.:—ink-pellets and bottle, pens (3 doz.) and holders 2, indelible pencils 4, labels 100, paper (½-quire), note-book and pencil, book of specification-tallies and pencil;

12. Corkscrew, gimlet, screwdriver.

The following (marked in italics above) might with advantage be added:—Darby's Capsicum plasters, Carbolic Acid tabloids, Glycerine, Pot. Chlor. et Ferri, Mag. Sulph., Bismuth, Pot. Iod., Iodine, Liq. Epispast., Ferri et Quin. Cit., Antipyrine and Caffeine, Hyd. Ox. (for a stimulating ointment), with a few suspenders, a metal syringe, and tubes with funnel for rectal and gastric lavage. More iodoform and boracic powder, more castor-oil, and a considerably larger supply of turpentine or other liniment and of vaseline are needed. Some means of testing urine for albumen should be provided; and before long it is to be hoped that a small microscope and a supply of typhoid culture with Widal's tubes will be furnished and put in constant use. As yet, however, this would be premature. On the other hand the ergot is probably useless in arresting hæmorrhage, pilocarpine could hardly conceivably be used in the field and the olive-oil seems superfluous.

The following cases, roughly speaking, have therefore *to be sent to the base*:—*Fevers of three days' continuous* duration (including enteric, pneumonia and acute rheumatism), intractable diarrhœa, nephritis, pleuritic effusion, dry pleurisy if persistent and severe, uncompensated cardiac lesions (very rare on active service), malarial cachexia and other cases of pronounced debility, intractable poisoned wounds of limbs, heat-stroke after third attack, melancholy or mania, severe fractures, sprained ankles and synovitis of knee, and all gun-shot and shell-wounds, except mere grazes.

The treatment given above is materially modified by the absence of some useful drugs and by the exhaustion of others. But it is generally possible to ensure the most important part of the treatment in the form of *rest, rest to the digestive organs in the form of milk and* bovril, rest for the sick by ordering "To be carried on transport-waggons," "Light duty two days" or "Excused out-posts," rest for a saddle-sore by attending to the under-clothing and ordering "Excused riding two days." At the same time in work at the front the

extreme must be avoided; men slightly ill or weary must often be made to march and continue their duties; and sprains, slight fractures, cases of synovitis and old adhesions after wounds must be moved earlier and more freely than under ideal conditions of practice.

B. No. 2 MEDICAL PANNIER, containing material.

1. Dressings: double cyanide gauze in 6-yard packets (48 yds.), ditto wool in 4-ounce packets (16 ozs.), boric wool in 2-ounce packets (6 ozs.), loose woven salembroth bandages (3 doz.), triangular ditto (1 doz.), calico (4 yds.), jaconet (3 yds.), black waterproof (4 yds.), spongio-piline (½ yd.).

2. Canvas housewives (2), containing common and safety-pins, sewing-needles and thread, surgical needles, tape and scissors.

3. Splints: 1 long jointed wooden thigh splint, 6 sheets of perforated zinc 23in. × 9in. with shears, anvil, hammer, and rivets, tape (12 pieces).

4. Plaster: adhesive tape (6 yds. × 1in.) 6 tins, adhesive indiarubber 1 tin, transparent isinglass (12 yds. × 1in.) 2 tins.

5. Drainage-tubing (3 sizes in solution), catgut in carbolized oil 1 tube.

6. Set of 3 tinned copper dressing basins.

7. Screw tourniquet.

8. Pouch of dental forceps, 3 pairs—hawksbill roots, lower wisdoms and upper roots.

9. 2 prescription books.

10. For emergency food: bovril (for 32 pints), extract of meat (for 32 pints), tin-opener, and food-warmer with spirit lamp.

Besides these panniers, field-hospitals and bearer companies are also supplied with some or all of the following:

C. FIELD FRACTURE BOX (weight 72 lbs.), plaster of Paris with instruments, perforated zinc with instruments, paste-board, another jointed thigh splint, counter-extension apparatus, and 100 bandages.

D. GENERAL FRACTURE BOX (weight 94 lbs.), double-inclined McIntyre, 2 jointed thigh-splints, 6 splints or pairs of splints in wire for forearm, upper-arm and thigh, 2 sets of japanned leg-splints and cane-splints, Salter's cradle, dislocation apparatus, counter-extension apparatus, paste-board, gutta-percha and plaster of Paris (with instruments and material) for splints, wool, tow and bandages.

E. ANTISEPTIC CASE (43 lbs.), bandages, dressings, drainage-tubing, silk, gut, and housewives.

F. SURGICAL HAVERSACKS (7 lbs., one for each bearer-squad), containing small dressing-case, hypodermic case, a few dressings and a few splints and emergency-remedies.

G. MEDICAL COMPANION (13 lbs., for sergeant of each stretcher-section of 4 squads), containing pill and tabloid tin, hypodermic case, chloroform, housewife and a few splints, bandages, catheters, and other emergency-remedies.

H. SURGICAL SADDLE-BAGS (32 lbs. the pair), with hypodermic and dressing cases, 2 dozen instruments and other surgical material.

When, however, a section of a field-hospital is sent off as was the case for two months with General Smith-Dorrien's (19th) Brigade, these boxes may be made up to suit the case; and in that instance a No. 1 Medical Pannier, a field fracture-box and an antiseptic case were adapted for the purpose.

Since aseptic surgery, as understood in the London hospitals, is impossible in the field, the constitution of these cases leaves little to be desired; but the splints provided should be revised, and inasmuch as wood is not always available, whereas long biscuit-tins are, metal corner-clamps might perhaps be provided, with which some very useful tin-splints might be made. At present it is impossible to make a good leg-splint, with foot pieces, from the materials provided.

Wolvehoek Station, O.R.C.,
September 14th, 1900.

THE ROYAL HOSPITALS' COMMISSION, S. AFRICA.

The proceedings of the Hospitals' Commission are creating considerable interest out here and the local papers report the evidence at length. Although one may not criticize the arrangements in a public letter, it is safe to say that all medical officers interested in the Commission, both military and civil, are anxious for it to get to the very bottom of things, whether for the improvement of the service in a future war or for the vindication of the authorities in this. There can be little doubt that the main conclusion of the Commission will be highly favourable to the medical arrangements, which compare favourably with those of any previous war and with the management of most other branches of the army. There can be little less doubt that certain details will be found to have been at fault and that changes of considerable magnitude may be suggested.

One of the chief points at issue is that of the transport. Had the medical service possessed its own transport, the surgeon-general would undoubtedly have equipped the ambulances and field-hospitals as completely for the Paardeberg march as he had previously equipped them for Lord Methuen's battles, where transport was to a large extent supplied by the railway. There would, accordingly, have been considerably less suffering on the march. On the other hand, the Chief of the Staff would thereby have been deprived of a considerable proportion of the transport in the country, and the invasion of the Free State would have been correspondingly delayed. Again, had the P.M.O. of the field-force been responsible for his own transport, the 19th Brigade would not have been obliged to trek from Bloemfontein to Pretoria before being joined by its field-hospital; but the forward move from Bloemfontein would have been delayed in proportion. The ideal is certainly for the transport to be sufficient for all departments of the army; and then it matters little who has control of it. The question is whether when the transport is deficient, it is best for the Generals to have a free hand in its distribution or for some of it to be securely locked up in the hands of the medical authorities. To this latter

course, from some of the evidence given by General Kelly-Kenny and others, there will be considerable objection raised by the combatant officers.

If the medical service is eventually provided with its own transport a further question arises in the management of this transport. Undoubtedly, if this is arranged, the senior or the principal medical officer of each unit must be ultimately responsible for his own. But the management of transport,—the direction of the wagons on the march and the repair of defects, the payment and discipline of two drivers for each wagon, the care and replacement of ten mules or sixteen oxen for each team,—is a very large labour, for which the medical officer is no more or less fitted than any other officer. This would add very materially to the purely business-work of the medical officer, which is already excessive. It is to be considered whether the services of regimental officers should not be enlisted, as in the Ordnance Department and Army Service Corps, to manage the business of each medical unit under the control of the principal medical officer. A similar arrangement exists in the German army, in which a branch called the Intendauber manages all the business-part of the army, including supply, transport, ordnance and the non-technical work of the medical department; and the English system of quartermasters is a step in the same direction. Such an arrangement is economical, for the regimental officer is rightly less expensive than the medical officer. It is advantageous to the medical officers, who are thereby to a large extent set free to devote their attention to the strictly technical work of their profession.

Another question which the Commissioners wish to fathom is the accuracy of Mr. Burdett-Coutts' statement that civil-surgeons have been made to sign a contract promising not to criticize in the public press. Your correspondent can at least say that he never heard of any such promise being made or demanded. By the original form of contract civil-surgeons only undertook to obey orders given them by officers in the services. They were not subjected to the Queen's Regulations and no order was issued on the subject until early in February, when the Surgeon-General circulated an order, drawing attention to the Queen's Regulations on the subject and making civil-surgeons responsible for any extract, even from their private letters, that their friends might insert in the public press. It is obvious that when civilians are serving with the army they should be subjected to the same general rules of discipline; and it was probably only by inadvertence that a clause to this effect was not inserted in the form of contract. It is only a pity that some accredited medical war correspondents should not have been sent out to undertake the same function on behalf of the public in respect of medical management in the army that is so ably undertaken in the other aspects of war by the existing representatives of the press. Such correspondents as have been commissioned to write on medical matters have either confined their attentions to base hospitals, or have made flying visits, or else have been compromised by being officers of the R.A.M.C. and so subject to the Queen's Regulations as regards criticism.

The Commissioners may be expected also to make some pronouncement on the subject of nursing in the Army. Hitherto the nursing has been entirely carried out by male nurses or orderlies, the nursing-sisters being really in a position very similar to that of the night-sisters at Guy's, although their place was not precisely defined. In future it may be expected that in operations on a large scale the nursing at the General and Stationary hospitals will be to a large extent carried out by female nurses, while it would be a good thing if the large civil hospitals at home could see their way to training and employing a small staff of male nurses, for instance, in the accident wards, who might be used as a nursing reserve for the army.

Another question in which the need of reform has been proved to most officers of the R.A.M.C., who are of course the chief authorities on work at the front, is the anomalous position of the Bearer Company. The duties of this unit are to pick up and carry in their ambulance wagons during the day's march patients for the Field Hospitals to which they are handed over at the end of the day. As these two units are at present entirely separate, friction occasionally ensues; and in future they should be under one command. Indeed, the whole existence of a Bearer Company of fifty men, who are only wanted on the rare occasions of a general action, is much criticized and may be reported on by the Commission.

As to the position of civil surgeons, it has been fully shown that a sufficient supply can be obtained, practically at a moment's notice, on such terms and for such work as have been offered in this war; and the use of a reserve of medical officers is therefore not apparent. It appears, too, that the present system of engaging them as civilians without giving them temporary rank is perfectly satisfactory; but it would save a good deal of friction and trouble if the civilian surgeons could be directly under the control of a chief civil surgeon, such for instance as Mr. Makins, Mr. Bowlby, or Mr. Fripp, who would sympathise with the point of view both of civilian and military surgeon. The readiness with which junior medical men have come forward on this occasion also suggests their employment in time of peace for a year's service at a time to fill up the gaps in the service, which are at present responsible for most of the grievances of the R.A.M.C.

As to the more scientific questions—the precaution against enteric fever on a campaign and the possibilities and need of systematic records and research in military medicine and surgery on active service, both questions of the very highest importance—the Commission is hardly in a position to judge; and the rest of its report will probably be occupied with the difficult question of Red Cross and local aid and with incidental mishaps in the arrangements. It goes without saying that all ranks, both military and civilian, will be acquitted of the main

accusations that have, although only occasionally, been made against them.

Your correspondent gave his evidence on board the train on which the Commission live and move and have their being. At the time they were travelling up the line from Vredeford Road to this station on their way to Pretoria. They hoped to follow Lord Roberts to Belfast, then to travel through Natal and finally to return by this line again to Cape Town. It is to be hoped that they will be able to get up to the front and see for themselves the working of field-hospitals, bearer-companies and convoys. By such an experience they would be able to judge of the difficulties of campaigning far more easily than by all the hearsay descriptions of which they must by now have grown weary.

There may be some difficulty in persuading the adverse critics to give evidence. A Guy's man who has had an extensive and not always fortunate experience in the war, remarked privately that he would give evidence if asked to do so, but would not think of offering his opinions. As he has for the most part been in subordinate positions in odd units, it is hardly possible that the Commissioners will hear his experiences and opinions, which have been carefully thought out and are of considerable importance. It is to be hoped that such men may volunteer their services to the Commission. Any doubt as to the completeness of its investigation would be most unsatisfactory either to the House of Commons, the medical profession or the public at large. It is to the interest of officers of the R.A.M.C. that they should bring all their most rabid critics before the judgment-seat.

The Commissioners' train travels under the protection of the Red Cross, and consists of four or five splendid saloon-coaches, with a complete staff of servants and waiters in uniform, shorthand-writers, typewriters and secretaries. The Secretary to the Commission, Major Tennant, C.B., wired on the previous day to the writer, asking him to be so kind as to give evidence; and on his arrival on board the train, acted as a most generous host. After luncheon, your correspondent was summoned to the saloon, in which he was examined by the five Commissioners for the space of half-an-hour or more, no one else but the shorthand-writer being present. Witnesses are asked to give their evidence in their own way, it being expressly pointed out that the Commission wishes only to consider the question of the medical arrangements for the care of the sick and wounded in this war, and not questions as to the organisation of the R.A.M.C. After each paragraph of evidence, a question or two is put by one or other member of the Commission; but there is little interruption, and such cross-examination as is indulged in, although it may be worrying, is no more than is necessary to a judicial enquiry.

On the whole, there can be little doubt but that the Commission is doing its work most thoroughly, and will be able completely to set at rest the recent public disturbance on the subject of medical arrangements during the war.

Of the movements of Guy's men one hears and sees little in these parts; but Dr. Washbourn passed through for Pretoria yesterday, and Mr. Glover is always turning up, each time in a different capacity. When last seen here, he had been promoted from Private to Sergeant-Major in the C.I.V. To-day he appears with a star on his shoulder-strap, having been appointed Lieutenant and Quartermaster in the New South Wales Army Medical Corps. On the last occasion he had compassed most of the Orange River Colony under General Bruce-Hamilton. Since then he has been through the Transvaal as far as Belfast, and now has been through this Colony again with General Hunter as far south as Senekal.

The rains have begun with a tremendous downpour a fortnight ago; and the veldt is already turned green, to the joy of all our unfortunate horses and beasts of burden.

F. E. FREMANTLE.

South African Memorial Fund.

(This Fund has for its object the erection of some permanent Memorial in the Hospital to those Guy's men who have fallen in South Africa.)

FIRST LIST OF SUBSCRIBERS.

	£	s.	d.
A. W. Brailey, M.D.	5	5	0
A. D. Fripp, M.S.	5	5	0
An Admirer of Guy's, per A. D. F.	5	0	0
T. Bryant, M.Ch....	2	2	0
C. Spurrell, F.R.C.S.	2	2	0
H. J. Campbell, M.D.	1	1	0
H. A. C.	1	1	0
C. H. Fagge, M.S.	1	1	0
J. Fawcett, M.D.	1	1	0
C. H. Golding-Bird, M.B.	1	1	0
C. E. Groves, F.R.S.	1	1	0
L. H. McGavin, F.R.C.S.	1	1	0
A. W. Ormond, F.R.C.S.	1	1	0
G. H. Savage, M.D.	1	1	0
L. E. Shaw, M.D.	1	1	0
W. Hale White, M.D.	1	1	0
W. A. E. Waller	1	0	0
A Colleague	0	10	6
Deelfontein	0	10	6
Dresser	0	10	6
Khaki	0	10	6
Wynberg	0	10	6
R. H. J. Swan, M.B.	0	10	6
1899	0	10	0
S. H.	0	10	0
Friend	0	7	6
A.	0	5	0
A. R.	0	5	0
B. D.	0	5	0
Dare Quam Accipere	0	5	0
Demos	0	5	0
D. W.	0	5	0
M.	0	5	0
P. A. F.	0	5	0
	£38	15	6

Nursing News.

MATRON'S OFFICE.

Miss Helen Frances Newton, who entered the hospital as Probationer in December, 1896, has been appointed Probationary Sister of Lydia ward.

On November 8th, Nurse Kew (Head Nurse in the Isolation ward), left the hospital on completion of her three years' training. Probationer Palmer has been appointed to succeed her as Head Nurse in the Isolation ward.

A little book entitled, "First Aid to the Injured," with special reference to accidents occurring in the mountains, by Dr. Oscar Bernhard, has been added to the Nurses' Library. The Matron thinks that this little volume should prove of much interest to nurses.

Davies-Colley Memorial Fund.

THE Secretary would be glad to receive all promised subscriptions as soon as possible, as it is hoped to close the Subscription List at an early date.

LIST OF FURTHER SUBSCRIPTIONS.

	£	s.	d.
Amount already acknowledged	321	11	0
Dr. C. Oldham	21	0	0
W. A. Brailey, Esq.	10	10	0
Dr. E. C. Perry	5	5	0
C. Higgens, Esq.	5	0	0
Dr. A. L. Galabin	2	2	0
G. Rowell, Esq.	2	2	0
W. A. Maggs, Esq.	2	2	0
C. T. Anderson, Esq.	1	1	0
Edward Armitage, Esq.	1	1	0
V. E. Collins, Esq.	1	1	0
J. N. Gardiner, Esq.	1	1	0
Dr. W. S. Handley	1	1	0
R. Bowen Hogg, Esq.	1	1	0
T. L. Jackson, Esq.	1	1	0
J. P. Pendlebury, Esq.	1	1	0
W. H. Roots, Esq.	1	1	0
R. P. Rowlands, Esq.	1	1	0
Dr. E. I. Spriggs	1	1	0
W. K. Steele, Esq.	1	1	0

THOS. G. STEVENS, Hon. Sec.

8, St. Thomas's Street, S.E.

From the Gazette's Special Pathologist.

NOTICES.

J. E., MIDDLESBROUGH.—No tubercle bacilli were found in the sputum, which appears to consist largely of saliva.

T. W., DEVONPORT.—The growth on blood-serum after incubation consists chiefly of staphylococci, but the Klebs-Löffler bacillus is also present in small numbers.

PATHOLOGIST.

Notices.

EXAMINING BOARD IN ENGLAND
BY THE
ROYAL COLLEGE OF PHYSICIANS OF LONDON
AND THE
ROYAL COLLEGE OF SURGEONS OF ENGLAND.

The following are the dates on which the Examinations will commence in the year 1901:—

FIRST EXAMINATION.

*CHEMISTRY AND BIOLOGY.—Tuesdays, January 8, March 26, July 23, October 8.

PRACTICAL PHARMACY.—Wednesdays, January 9, March 27, July 24, October 9.

SECOND EXAMINATION.

PHYSIOLOGY.—Thursdays, January 10, March 28, June 27, October 10.

ANATOMY.—Fridays, January 11, March 29, June 28, October 11.

THIRD OR FINAL EXAMINATION.

†MEDICINE (1st Paper).—Tuesdays, January 15, April 9, July 2, October 15.

MEDICINE (2nd Paper).—Wednesdays, January 16, April 10, July 3, October 16.

MIDWIFERY.—Thursdays, January 17, April 11, July 4, October 17.

SURGERY.—Fridays, January 18, April 12, July 5, October 18.

* The Examination in Practical Chemistry will be held on Fridays, January 11, March 29, July 26, October 11.

† Candidates who registered as Medical Students before the 1st January, 1892, are not required to sit for the First Paper in Medicine.

Candidates intending to present themselves for Examination are required to give notice in writing to the Secretary of the Examining Board in England, Examination Hall, Victoria Embankment, London, W.C., *fourteen clear days before the day on which the Examination commences*, transmitting at the same time the required Certificates.

All Fees must be paid not less than three days prior to the day on which the Examination commences.

Synopses indicating the range of Subjects in the Examinations in Chemistry, including Chemical Physics, Practical Pharmacy, Elementary Biology, Physiology, Forensic Medicine, and Public Health may be obtained together with the Regulations.

N.B.—Books of Questions set at the several Examinations of the Board for each year from 1887 to 1900 may be had on application to Messrs. Taylor and Francis, Printers, Red Lion Court, Fleet Street, London, E.C. Price 6d. each, Post free 6½d.

FREDERIC G. HALLETT, *Secretary.*

UNIVERSITY OF OXFORD.

EXAMINATION FOR THE DEGREE OF BACHELOR OF MEDICINE.

MICHAELMAS TERM, 1900.

The Regius Professor gives notice that the Examinations for the Degree of Bachelor of Medicine will commence in the Examination Schools on Wednesday, December 5th, 1900, and that they will be held in accordance with the following Time Table :—

FIRST EXAMINATION.

Wednesday, December 5. Examination Schools.
I. 9.30 a.m. Organic Chemistry.
II. 2 p.m. Materia Medica.
Thursday, December 6. Examination Schools.
III. 9.30 a.m. Anatomy.
IV. 2 p.m. Physiology.
Friday, December 7. Chemical Department, Museum.
V. 10 a.m. Practical Examination in Organic Chemistry, and viva voce.
Saturday, December 8. Chemical Department, Museum.
VI. 10 a.m. Practical Examination in Materia Medica, and viva voce.
Monday, December 10. Physiological Department, Museum.
VII. 10 a.m. Practical Examination in Physiology and Histology, and viva voce.
Tuesday, December 11. Department of Human Anatomy, Museum.
VIII. 10 a.m. Practical Examination in Human Anatomy, and viva voce.

SECOND EXAMINATION.

Wednesday, December 5. Examination Schools.
I. 9.30 a.m. Principles and Practice of Medicine.
II. 2 p.m. Principles and Practice of Surgery.
Thursday, December 6th. Examination Schools.
III. 9.30 a.m. Midwifery and Diseases of Women and Children.
IV. 2 p.m. Pathology.
Friday, December 7. Examination Schools.
V. 9.30 a.m. Forensic Medicine and Hygiene. Medical Department, Museum.
VI. 2 p.m. Practical Examination in Pathology, and viva voce.
Thursday, December 13. Radcliffe Infirmary.
VII. 10 a.m. and 2 p.m. Clinical Examinations in Medicine and in Surgery.
Written Reports of cases, and viva voce at bedside.
Friday, December 14. Medical Department, Museum.
VIII. 9 a.m. Practical Examination in Medicine, Surgery, and Midwifery, and viva voce.

J. S. BURDON-SANDERSON,
Regius Professor of Medicine.

The Secretary to the Boards of Faculties gives notice that the Names of Candidates, accompanied in each case by a Certificate dated and signed by the proper officer of a College or Hall, or the Censor of Non-Collegiate Students, stating that the Candidate's name is at that time on the books, must be transmitted to or given in at his Office in the Clarendon Building, not later than 10.30 a.m. on Wednesday, November 21st, 1900.

PLAGUE.

The Council of the Incorporated Society of Medical Officers of Health have arranged a lecture and demonstration on this disease. Mr. Cantlie has undertaken the task of dealing with the æticological and clinical parts of the subject, and Dr. Klein the bacteriological. Dr. Chalmers will describe the suitable preventive measures, more especially with regard to the line followed at Glasgow. The meeting for this purpose is fixed for *2.30 p.m. on Saturday, November 10th next*, the day following the ordinary meeting of the society, and will be held at the Examination Hall of the Conjoint Colleges, Thames Embankment. The meeting will be open to the whole profession, but admission will be by ticket, application for which is to be made to the Hon. Secretaries, 197, High Holborn, W.C.

Reviews.

The price of books submitted for review should in every case be stated.

First Aid to the Injured. By Dr. Oscar Bernhard. Translated from the German by Michael G. Foster, M.A., M.D. (Cantab.). (London: T. Fisher Unwin). 2s. 6d.

On the matter contained in this little volume Mr. Unwin is certainly to be congratulated: on the style of production, however, both as regards the type and the binding, we cannot congratulate him. We have become accustomed to associate with the name of Fisher Unwin a very high degree of typographical excellence, but in the case of the book now before us we regret to find that Mr. Unwin's name appears on a gaudily-covered, German-printed article, savouring strongly of the ubiquitous "guides" which are met with abroad. When the irritation caused by the strange founts used in this book has been overcome, a feeling of satisfaction at the excellence of the letterpress takes its place, and with justification. Although primarily intended for use in mountainous districts, there is much that is of value even in the heart of London, and in clearness of diction and excellence of illustration, this book will be found to far exceed most of the other first aid manuals.

ALSO RECEIVED.—Hospital (weekly), Clinical Journal (weekly), Treatment, St. George's Hospital Gazette, Polyclinic, Treatment, St. Bartholomew's Hospital Gazette, St. Thomas's Hospital Gazette, Therapist, Broadway, London Hospital Gazette, University of Durham College of Medicine Gazette.

Sport.

Rugby Football.

GUY'S 1st XV., v. "OLD CROCKS."

"OLD CROCKS," 13 POINTS; GUY'S, 7 POINTS.

This match was played at Honor Oak Park, on Saturday, November 3rd, and resulted in a win for the "Old Crocks" by 2 goals and 1 try to 1 penaly goal and 1 try.

In the first half the "Old Crocks'" forwards had matters very much their own way, enabling Wadson and Spon to score tries, one of which was converted. The try scored by Wadson was the result of some good passing by Ayre-Smith and Bagshawe.

Early in the second half, Wadson picked up from a loose pass, and with a long sprint along the touch-line, scored a fine try, which was converted. After this, the Guy's team improved, with the result that they scored one unconverted try, and O'Brien dropped a fine goal from a penalty. The Hospital forwards were very feeble, even allowing for the fact that they were overweighted, and the tackling of the whole side left room for vast improvement.

GUY'S v. CAMBRIDGE UNIVERSITY.

(CAMBRIDGE, 13 POINTS; GUY'S, 5 POINTS).

Played at Cambridge on October 17th. Guy's, with a team strengthened by the inclusion of several old players, were able to give the strong Cambridge team a fairly good game. Losing the toss, Cambridge kicked-off against the wind, and play settled down in mid-field where a series of hard scrums was fought out. The Guy's forwards, playing well against a much heavier pack, secured the ball well, and eventually after a bout of passing among the outsides, the ball was transferred to Thomas, who in turn gave it to Wetherell enabling the latter to get over; O'Brien converted with a grand kick. On resuming play, the game became very tight, the Varsity relying on their heavy forwards who gradually worked the ball into our twenty-five. Here, after some loose play, Collett, one of the opposing centre three-quarters, dropped a goal. Half-time was then called with the score Guy's, 5 points; Cambridge, 4 points.

In the second half the game still consisted chiefly of forward play, and from a scrum in our twenty-five, Cambridge secured a try on the right, but this was not converted. Guy's now rushed the ball into the Cambridge twenty-five, but the full-back quickly transferred it into our territory, where from a throw-in Cambridge again scored, but were unsuccessful with the kick. However, shortly after, we were penalised for off-side tactics, and Segar kicked a goal from a very difficult position. To this the Hospital replied with spirit, and McEvedy intercepting a pass raced up the field and transferred to O'Brien; the latter, finding himself in difficulties, kicked across, and but for Wetherell having damaged his hand in the first half we should have undoubtedly scored. Time was then called with the score Cambridge, 13 points; Guy's, 5 points.

REMARKS.—The Hospital was unlucky in being beaten by so large a majority, and also in Wetherell being practically disabled during two-thirds of the game. The forwards all played well, more especially Mullins, and Trail, and Wetherell, until his accident, was quite his old self. Of the new men, McEvedy showed up well, but should pay more attention to his tackling. Milsom followed up well. Team:—

GUY'S.—E. M. Harrison (back); P. F. McEvedy, A. O'Brien, C. D. Pye-Smith, M. G. Louisson (three-quarter backs); F. C. Wetherell, S. C. Brown (half-backs); H. A. Cutler, R. C. Mullins, D. H. Trail, T. P. Thomas, R. C. Lawry, E. H. B. Milsom, R. G. Anderson, A. H. E. Wall (forwards).

GUY'S v. ROSSLYN PARK.

(ROSSLYN PARK, 20 POINTS; GUY'S, 5 POINTS).

This match was played on our opponents' ground at Richmond on October 27th. Guy's won the toss and played with the wind. After the kick-off the play was in our twenty-five, and the Rosslyn Park forwards being the heavier came very near scoring. However, by some good play in the loose, the ball was carried to mid-field, where after a series of scrums, O'Brien made a good run and transferred to Morgan, the latter scoring far out; O'Brien converted with a grand kick. Rosslyn Park now played up with renewed vigour, and a forward rush resulted in them scoring a lucky try under the posts. This was converted, and at half-time the score was 5 points each.

On restarting, Rosslyn Park with the wind in their favour, began to attack, and by some good passing among their three-quarters enabled their outside right to score behind the posts; the try was converted. Shortly afterwards the same player again scored, this time by a really brilliant run; a goal again resulting. Guy's, who up to this had not been playing at all well, now put a little vigour into their efforts, and worked the ball down into our opponents' territory, and for a short time hotly attacked, but were unable to break down the home defence. Rosslyn Park now in turn attacked, and by a good forward rush scored once more; the kick at goal was again successful. A little later, after a series of scrums, Morgan intercepted a pass and raced down the field and almost scored, but was just pulled up by the full-back within a few yards of the goal-line. Shortly after this, time was called with the score Rosslyn Park, 20 points (4 goals); Guy's, 5 points (1 goal).

REMARKS.—Harrison kicked well, but is rather weak in defence. The halves were out-classed, and when they did get the ball, were too slow. The three-quarters made good use of the few opportunities they got in attacking, but must learn to collar their men low and hard and not depend upon intercepting alone. The forwards at times played well, but should break up more quickly and get across the field to help the backs; two

tries might have been saved in this way. They also must learn to bring their men down and not let them get away again, and not lose their heads in the loose The packing, too, was at times disgraceful. Team—

GUY'S.—E. M. Harrison (back); E. Morgan, C. D. Pye-Smith, A. O'Brien, P. F. McEvedy (three-quarters); M. G. Louisson, L. C. Brown (halves); H. A. Cutler, A. H. E. Wall, R. C. Lawry, R. G. Anderson, E. H. B. Milsom, B. Glendining, A. R. Thompson, G. T. Collins (forwards).

Association Football.

GUY'S 1ST XI. v. REDHILL.—SURREY SENIOR CUP

(GUY'S, 4 GOALS; REDHILL, 2 GOALS.)

Played at Redhill on Saturday, November 3rd. The ground was fairly level, but spoilt by the recent rains, and was on that account rather boggy in places. Guy's lost the toss and kicked off. The opening exchanges were very equal, first one side and then the other pressing. Some fifteen minutes after the start Guy's began to show their superiority, but the forwards appeared unable to shoot straight, and lost their chances. The opposing team made one or two good runs up, but were frequently, when about to shoot, ruled off-side. At half-time Guy's were still pressing. The teams crossed over and the visitors, running through the defence, scored their first point by a lucky shot, which went through the goal-keeper's legs. Redhill had not recovered from this when another goal was scored against them by Barber, after some very pretty work by the inside forwards. This put the opponents on their mettle; they pressed hard and scored through a mistake by one of our backs. The home team again pressed, but nothing came of it. Guy's scored again about half-way through the second half. The opponents retaliated, and obtained a lucky goal by a cannon off the post. The game now became scrambling in character, and after Guy's had obtained another goal, they left the field victors by 4 goals to 2. Guy's were much the better team, and had the forwards only managed to shoot better in the first half, we should have had a much larger majority, although in justice to them it must be said that the opponents' goal-keeper was distinctly good. Team:—

GUY'S.—F. M. V. Smith (goal); M. W. Robson, S. M. Wells (backs); H. Bacon, J. Goss, J. Cameron (halves); T. H. Edey, H. Barber, T. A. Chignell, E. N. Norton, J. Wilson (forwards).

GUY'S 2ND XI. v. LORN.

SURREY JUNIOR CUP.—SECOND ROUND.

GUY'S, 4 GOALS; LORN, 2 GOALS.

Guy's won this match by 4 goals to 2, at Honor Oak Park on Saturday, November 3rd. Lorn took the ball up after the kick off, and scored a goal in the first two minutes. Guy's were playing hopelessly for the first quarter of an hour; a complete change, however, soon took place. Bell took the ball up from half-way, and shot, the goal-keeper saved, but Roberts, getting possession, easily scored. Soon after this Crofts scored again with a long shot. Lorn equalised, and Crofts put us ahead during the next five minutes. Half-time was called soon afterwards.

The second half was fast and well contested. Towards time Lorn had a free-kick in our goal-mouth, and were distinctly unlucky in not scoring, the ball going through without touching anyone. Directly after this Guy's went away and Peall scored. Time was called soon after this, with the result as stated.

Gardiner in goal played extremely well. Both backs played most reliable games. The halves worked hard, but were inclined to be wild in their kicking. Team:—

GUY'S.—J. Gardiner (goal); A. Leeming, J. Braithwaite (backs); A. D. Crofts, J. Brailey, P. P. Cole (halves); H. L. Dent, A. H. Bell, W. O. Roberts, F. Morris, P. A. Peall (forwards).

Papers by Guy's Men.

An Address on the Surgery of the Stomach. With illustrative cases. By A. Ernest Maylard, B.S., M.B. Lond.—*Lancet*, 3rd November.

Appointments.

Dr. A. P. BEDDARD has been elected a Vice-President of the Dental Society.

NAVAL AND MILITARY.

Lieutenant-Colonel E. G. RUSSELL, I.M.S., Bengal Establishment, has retired from the service.

Major E. C. HARE, I.M.S., Civil Surgeon on return from furlough, is posted to Ganhatis, and appointed to hold civil medical charge of the Kamrup district.

Surgeon-Major D. ELCUM, I.M.S., retired, has been appointed for service in the Home District.

Surgeon-Captain E. T. CROUCH, 3rd (Duke of Connaught's Own) Volunteer Battalion the Hampshire regiment is promoted to be Surgeon-Major.

Surgeon-Lieutenant HARRY MUNYARD BROWNFIELD, 3rd Volunteer Battalion the Hampshire regiment, is appointed Surgeon-Lieutenant, Army Medical Reserve of Officers.

Birth.

SMITH.—On September 28th, at High Street, South Norwood, the wife of W. H. M. Smith, M.R.C.S. Eng. L.R.C.P., of a daughter.

Death.

CURRIE.—On October 4th, at Maritzburg, Natal, Winifred Jessie, daughter of Oswald James and Sarah Currie, aged seven months.

ED.—S. H.

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Calendar of Coming Events.

November, 1900.

Sat. 24.—Messrs. Lucas and Lane's take-in; Drs., H. Barber and G. F. Humpherys; Cl., J. A. B. Hammond.
1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Old Merchant Taylors, home.
II., Royal School of Mines, away.
G.H.A.F.C. I., Ramsgate, away.
II., Banstead, Home.
G.H.P.P.S., Pathological Meeting.

Mon. 26.—1.15 p.m., Clinical lecture by Mr. Targett.

Wed. 28.—1.30 p.m., Clinical lecture by Mr. Howse.
G.H.R.F.C., II., Boro' Road New Col., away.
IV., Dulwich College, III., away.

Thur. 29.—Messrs. Golding-Bird and Dunn's take-in; Drs., F. C. Wetherell and J. W. Grommett; Cl., L. E. Stamm.

Fri. 30.—Last day for names to be sent in for 1st, 2nd and 3rd M.B. Cantab. Exam.

December.

Sat. 1.—1 p.m., Clinical lecture by Dr. Pitt.
January Appointment List opened.
G.H.R.F.C., I., Blackheath, away.
II., Old Merchant Taylors, home.
III., Dulwich College II., away.
IV., St. Paul's School III., away.
G.H.A.F.C. I., Ewell, away.
II., Ewell 2nd XI., away.

Mon. 3—Exams. for M.D. and M.S. Lond. begins.
1.15 p.m., Clinical lecture by Mr. Higgens.

Tues. 4—Exam. for B.S. Lond. begins.
Last day for sending in Fees and Certificates for 1st, 2nd and 3rd M.B. Camb. Exams.
12 noon, Mr. Rowell's Demonstration on Anæsthetics.

Wed. 5.—1.30 p.m., Clinical lecture by Mr. Howse.

Thur. 6.—Messrs. Jacobson and Fripp's take-in; Drs., D. H. Trail and A. C. H. Gray; Cl., F. W. Sime.

Thur. 8.—January Appointment List closed.
G.H.C.U., Address by Albert Carless, Esq., M.S.

Sat. 8.—1 p.m., Clinical lecture by Dr. Pitt.
Last day for applying to Registrar for Form of Entry for Prelim. Scientific and Intermediate M.B. Lond. Exam.
Application to Med. Sch. Office for Schedules for 1st and 2nd Conjoint Exam. to be made not later than this date.
G.H.R.F.C., I., Croydon, home.
II., Croydon, away.
III., Blackheath School, away.
G.H.A.F.C., I., Surbiton Hill, home.
II., Surbiton Hill 2nd XI., away.
G.H.P.P.S. Paper by Mr. Stanley Hodgson on "Infective Endocarditis."

Guy's Hospital Gazette,

NOVEMBER 24, 1900.

An Elizabethan Handbook of Therapeutics.

A paper read before the Physical Society on Saturday, November 3rd, 1900, by Mr. H. L. Eason.

Mr. Chairman and Gentlemen,—When in the latter part of this summer I had the honour of being requested by your secretary, Mr. G. Bellingham Smith, to read a paper before this society, my courage failed me, and for awhile I hesitated to accept the invitation, for two reasons; firstly, having now been at Guy's some seven years my confidence in addressing you on any subject I know nothing about is quite seven times less than it would have been when I entered this hospital; secondly, a much more important reason, the invitation from Mr. G. B. Smith contained the express advice that I should not read a paper on anything connected with human eye, as it was quite certain that no one would attend to listen to it. This was disconcerting, but, at this present time, knowing more of eye-work than I did then, I am getting more reconciled to his advice. I finally consented to read a paper, under the compromise that it should not of necessity treat of modern medicine in any shape or form, but might rather be of some historical or antiquarian interest.

In writing any paper I am convinced that the title is everything. An attractive title having been found, one's labours are then directed to writing up to it; a method which saves one the trouble of writing a valuable thesis and then being compelled to abandon it for need of a good label. This theory is the justification of my paper to-night. "An Elizabethan Handbook of Therapeutics," savoured just correctly of the art of medicine without

committing me to any excess of Hippocratic erudition; in fact, beyond introducing to you the subject of my talk, I shall do nothing; afterwards this ancient apothecary shall speak for himself.

The full title of the book in question is set forth on its title page. "The Herball or Generall Historie of Plants, gathered by John Gerrard of London, Master in Chirurgerie, very much enlarged and amended by Thomas Johnson, Citizen and Apothecarye of London. London, Printed by Adam Islip Joice Norton & Richard Whitaker Anno 1633. Folio, pp. 1631."

This was the earliest attempt to write in English a full account or review of the flora of the British Isles, and was so thorough in its execution that its name has been a household word ever since its publication, and despite the lapse of two hundred and fifty years it still remains a valuable and trustworthy book of reference.

The greater part of the book is naturally purely botanical, but so wide is the scope of it that to every plant is appended a table of its medicinal virtues, and it is in this therapeutic portion of the book that most interest lies for the modern physician. Of course, before criticizing the medical knowledge displayed therein it is imperative to remember the time and place in which it was written. No British Pharmacopœia had yet been written. Harvey had not discovered the circulation of the blood; the Royal Society, the first really scientific body in England had not been founded, and there was as yet no foundation or solid work of reference on which to build a system of medicine. The condition of affairs at the time is very well described by Dr. J. F. Payne in his recent biography of Thomas Sydenham. He says, "Never was there a period when the medical profession underwent a more rapid change than it did in London after the Restoration. Before the Civil Wars, physicians in London had been a very limited, and on the whole, a very uniform class. They were guided chiefly by the Galenical tradition which had at first only acquired new strength by the revival of medical learning, and in this revival Linacre and other early fellows of the College of Physicians, played a distinguished part. The great discovery of Harvey, which seems to us now so signal a landmark in the history of medicine had introduced no change in its practice. The traditions of the classical school still bore almost undisputed sway and the English physician was still the formal and learned scholar such as Linacre had intended to make the type of a Fellow of his College.

"The only other school of medicine which had any distinct name, or formed a distinct school in practice, was the Chemical or Spagyrical, constituted by the disciples of Paracelsus and Van Helmont. But in England at least the chemical physicians were at the time a small and discredited class. Their exorbitant pretensions to infallible skill, and their trafficking in secret remedies, caused them to be ostracized by the College of Physicians. The very name 'quack,' originally 'quacksalber,' invented for them, is an index of their position; for this meant nothing more than 'queck silber' or quick silver, the German name for mercury, a drug the use of which was one of their distinguishing marks. The long controversy of the College of Physicians with a certain Anthony, a chemical physician who had a secret remedy called 'Aurum Potabile' or 'Potable Gold,' shows the essential antagonism between the quacks and regular practitioners. . . . Another set of irregular practitioners were the astrologers, who about the middle of the century abounded in England. Not content with drawing horoscopes, and ordinary fortune telling, men like Culpepper, Lilly and others trespassed on the province of the physician and practised physic by the light of the stars, a method once indeed recognised in orthodox medicine, but by this time discredited. In addition to all these there was a great crowd of base empirics, herbalists, water casters, and the like, who made no pretence to chemistry or astrology, but with abundant effrontery offered to sell remedies for every complaint. Mountebanks from country fairs blowing their trumpets in the streets, hawkers of amulets, charms, and nostrums; charlatans and impostors of every name and colour plied their trade with little hindrance on the part of the law. All through the seventeenth century both physicians and surgeons complain bitterly of these ignorant pretenders. Laws were made against them with powers given to the College of Physicians to enforce, but there seems to have been great difficulty in making them effectual, so that the quacks and empirics flourished abundantly."

In addition to all these were apothecaries, countless in their numbers, both those who honestly dispensed the doctors' prescriptions, and also those, not unknown in the present day, who made more money by the prescriptions in their hands than did the physicians who wrote them, prescribing on their own initiative for anyone who came into the shop.

John Gerrard was himself a properly qualified surgeon, but was more of a herbalist than surgeon in practice, and being keeper of the Physic Gardens devoted himself to the collection and classification of a materia medica, a colossal task in those days of mingled ignorance, superstition, and credulity. The problem of how the effect of any drug upon any particular disease was originally discovered, must have occurred to all of us while learning our materia medica, and our sympathies have gone out to those early pioneers of drug taking. If the truth of the modern aphorism be allowed that "he was a bold man who ate the first oyster," I think you will also agree with me that he was a sad man who drank the first drachm of croton. The long vista of countless experiments on mediæval patients, from kings to cobblers, with all the herbs of the fields in heroic doses, to say nothing of mixtures containing every conceivable animal nastiness, cheerfully administered by physicians and apothecaries of those times, furnishes a large field for reflection and provokes lively gratitude for having been born later. To illustrate my meaning let me quote here from a contemporary book of therapeutics, an edition of the works of Dioscorides, printed

at Leyden, in Holland, in 1550. Two extracts give you the perspective :—

"Animalium urina, ut eorum natura, plus minus ve calida est. Omnium debilior, et minus calida est humana, huic proxima porcina. Apri acris est. Ex hac thusci mixta cum oleo, ac in sua vesica relicta, cum ad fumum appenderint, quousque spissitudinem mellis contrahat ad vermes infantium utuntur ac inde mirabilis sequitur effectus."

"Inter animantium stercora laudat Galenus, bovinum, caprinum, crocodilinum caninum et hujus mirabile effectum recitat si arte et moto educetur. Aqua e stercore humano per alembicum extracta, valet ad fistulas, ad erodentia ulcera, ad ulcera capitis manantia, ad albuginem oculorum, ad cancros, extra applicatum. Oleum quod ab aque, aucto circa alembicum igni distillat, valentior est ad jam dicta."

Before we could possibly arrive at the knowledge represented by the British Pharmacopæia, it follows almost as a matter of course that nearly every living plant in England must at one time or another have been either taken or administered empirically for every known disease: by this laborious method the failures were gradually excluded and the valuable remedies retained. Of necessity this long process took centuries, for before any herb could be definitely excluded from a list of useful drugs, medical opinion must have been fairly unanimous as to its inefficacy, and unanimity of medical opinion is not so common. Gerrard, who had the courage to write down in black and white what he believed to be true, gives us a vivid picture of the confused and chaotic state of *materia medica* in his time. In his great work the virtues of all plants from Digitalis to Chickweed are set out at great length; nearly every plant is a specific for at least a score of diseases, and no plant is too insignificant to be used in medicine. Still confused as the results may now appear, the task of collecting all this mass of evidence and arranging it in some methodical form must have been enormous, and the completion of such a work of reference marks a great step in the history of English botany and medicine.

This book, a large heavy folio of over 1600 pages, was not entirely original, but was the outcome of several foreign works of the kind, being in a great part derived bodily from a History of Plants, published by Rembertus Dodonæus, a physician of Mechlin, in Brabant, in 1560. This was translated into English by one Dr. Priest, but he died before its completion and Gerrard incorporated Priest's translation into his own work, re-arranging it in many ways to suit the English flora. The edition before you is that of 1633 when Gerrard's original Herball was re-edited by Thomas Johnson, M.D., and very much enlarged. In fact, the greater portion of the completed work is due to the energy of this Thomas Johnson, whose name is usually neglected in favour of his better known predecessor, Gerrard, who takes all the credit from posterity.

The following short account of the lives of these two eminent herbalists may not be out of place as a preface to some consideration of their work. My authority for these details of their lives is the National Dictionary, edited by Sidney Lee.

JOHN GERRARD was born in 1545 at Nantwich, in Cheshire. He went to school at Willaston, two miles from his native place, and having studied medicine he travelled to Scandinavia and Russia, and also possibly in the Mediterranean. In 1562, Gerrard was apprenticed to Alexander Mason, a surgeon in large practice, who was twice Warden of the Barber Surgeons' Company. Gerrard was admitted to the freedom of the same company on December 9th, 1569, and was elected a member of the Court of Assistants on June 19th, 1595. Gerrard was then well known as a skilled herbalist. He was superintendent of the gardens of Lord Burghley, in the Strand, and at Theobald's, in Hertfordshire. He was living in Holborn, where he had a garden, to which he devoted great attention, and published a list of the plants therein in 1596. The only copy of that edition known to exist is in the Sloane collection in the British Museum. It is of peculiar interest as being the first catalogue of any one garden, public or private. A second edition, this time with English names as well as Latin in opposite columns, was brought out in 1599. Between these dates Gerrard had suffered from ague. In August, 1597, he was appointed junior warden of his company. In the previous year he had suggested that the Company should keep a garden for the cultivation and study of medicinal plants. A piece of land at East Smithfield was selected, but found unsuitable, and the purchase of a garden was never completed. In December, 1897, appeared the folio volume which has made Gerrard's name a household word. His Herball (London, J. Norton) was dedicated to Lord Burghley. This is in the main a translation by Dr. Priest of Dodonæus "Pemptades," arranged in the order of L'Obel's Adversaria; it contained more than eight hundred woodcuts, only sixteen of which were original, the majority being the identical cuts used by Bergzabern (better known as Tabernæmontus in his Eicones (1590), which were procured from Frankfort by the king's printer, John Norton. The volume has many of Gerrard's own remarks inserted, such as localities in various parts of England for scarce plants, and many allusions to persons and places of high antiquarian interest. He lays claim to a purely scientific interest, but accepts much from contemporary folk lore, which does not detract from the interest of his volume.

On January 15th, 1598, and again on July 20th, 1607, he was appointed an examiner for the admission of candidates to the freedom of the Barber Surgeons' Company, then exercising as complete a control of the surgeons practising in London as the various medical boards do at the present time. In 1604 he was granted a lease of a garden adjoining Somerset House, by the queen consort of James I., but in 1605 he parted with his interest in it to Robert Cecil, Earl of Salisbury, second son of Lord Treasurer Burghley. In the legal documents connected with his lease, Gerrard is described as "herbalist" to James I.

Upon payment of a fine of £10, Gerrard was released from the office of second warden and upper governor of his company on September 26th, 1605. He was chosen Master of the Barber Surgeons 17th August, 1607. He died in February, 1612, and was buried in St. Andrew's Church, Holborn (18th February), but there is no monument to mark the spot.

In 1633, Thomas Johnson edited a new edition of the Herball, which was so well received that a reprint of it, word for word, was brought out in 1636. In 1639 the Barber Surgeons' Company paid 25s. 6d. for a copy of Gerrard's Herball for their library.

So much for John Gerrard. Now for a few words concerning his even more gifted, though less known editor.

Thomas Johnson, M.D., botanist and royalist, colonel in the Civil War, was born at Selby, in Yorkshire, probably early in the seventeenth century. He seems to have received a good education, and to have become an apothecary in London in 1626. In 1629 he was in business on Snow Hill, City of London, where he had a physic garden, and had become an important member of the Apothecaries' Company. His first work was a short account of one of the herbarizing excursions which the Company was in the habit of taking. This, the first local catalogue of plants published in England, was entitled "Iter Plantarum Investigationis ergo susceptum a decem Sociis in Agrum Cantianum ann. dom. 1629 Julii 13 (London, 1629)," and an appendix of three pages headed "Ericetum Hamstedianum seu plantarum ibi crescentium observatio habita anno eodem 1 August."

Johnson seems to have been in Kent in 1626, and to have revisited both that county and Hampstead Heath, as in 1632 he published an enlarged edition of both lists. The plants are named in them according to Lobel, Dodoens and Gerrard. In 1633 Johnson published his most important work, "The Herball, gathered by John Gerrard, very much enlarged and amended by Thomas Johnson, citizen and apothecary of London." So great had been the progress of botany in the thirty-six years since Gerrard's original publication, that Johnson added over eight hundred new species in the list, and seven hundred figures, besides numerous corrections. The work, which contains about 2,850 descriptions, is commonly known by the name "Gerrard emaculatus," given it by Ray. Johnson seems, however, to have completed it in a year. It was reprinted in 1636 without alteration.

In 1634, Johnson published "Mercurius Botanicus sive plantarum gratia suscepti itineris anno 1634 descriptio," a description in seventy-eight pages of a twelve days' journey to Oxford, Bath, Bristol, Southampton and the Isle of Wight, with English and Latin names of the plants observed. In 1641 he issued "Mercurius Botanicus pars altera," describing a visit to Wales and Snowdon, and the discovery of many new plants.

In 1642, Johnson was made Bachelor of Physic by the University of Oxford, and M.D. on May 9th, 1643. In 1644, in a skirmish near Basing Castle in the royalist war, he was shot in the shoulder, "whereby" as the chronicler puts it "contracting a feaver he died a fortnight after."

But enough of biography, and let us give the book some attention. It is not a hand-book or pocket-book in any sense of the word, but a robust, grave, and solid leather-bound folio of over 1600 pp., in actual weight running to several pounds, the matter being very well printed on heavy, tough, lasting paper. The copy in question has evidently been well used, but is little the worse after two hundred and fifty years. On the title page there is a very fine steel engraving, with allegorical pictures of Ceres and Pomona, ideal portraits of Theophrastus and Dioscorides, and at the bottom the only portrait extant of John Gerrard, Master in Surgery, a typical Elizabethan worthy in pointed beard and ruff.

The dedication to Sir William Cecil, Lord Burghley is in keeping with the rest of the undertaking, philosophical, reminiscent of classic authors from Pliny downwards, and seasoned with a little wholesome flattery for the august patron.

It commences with the following phrases, quite characteristic of the ornate and euphuistic language of the age of Spenser.

"Among the manifold creatures of God (right honourable and my singular good Lord) that have in all ages diversely entertained many excellent wits, and drawn them to the contemplation of the divine wisdome, none have provoked men's studies more, or satisfied their desires so much as plants have done, and that upon just and worthy causes. For if delight may provoke men's labours, what greater delight is there than to behold the earth apparelled with plants, as with a robe of embroidered worke, set with orient pearles and garnished with a great diversitie of rare and costly jewels? If this varietie and perfection of colours may affect the eye, it is such in herbs and floures that no Apelles, no Zeuxis ever could by any art express the like; if odours or if taste may worke satisfaction, they are both so soveraigne in plants and so comfortable, that no confection of the Apothecaries can equall their excellent vertue. But these delights are in the outward senses; the principal delight is in the minde, singularly enriched with the knowledge of these visible things setting forth to us the invisible wisedome and admirable workmanship of Almighty God. The delight is great, but the use greater and joyned often with necessitie. In the first ages of the world they were the ordinarie meate of men, and have continued ever since of necessarie use both for meates to maintain life and for medicine to recover health. The hidden vertue of them such that (as Pliny noteth) the very bruite beasts have found it out, and (which is another use that he observes) from thence the dyars took the beginning of their arte."

Following this dedication comes a commendatory letter to the reader written in Latin by Lancelot Browne, M.D., of Cambridge, physician in ordinary to Queen Elizabeth and King James the first. This letter commending Gerrard's Herball to the reader is the only known writing of Lancelot Browne, who was one of those physicians

entrusted by the College of Physicians in 1594 to prepare the first authentic London Pharmacopœia. Dr. Browne died before the completion of this work, which only saw the light in 1618.

Then comes a congratulatory letter in Latin from Mathias de l'Obel, a famous foreign herbalist, whose classification of plants was Gerrard's chief guide in his compilation; then five poems in Latin in the Elizabethan pseudo classic style, all written in praise of Gerrard and his book by versifying physicians. Then follows a letter in English from Dr. St. Bredwell, Physician, to the reader, again extolling the virtues of the study of plants: after this a letter, also in English and of the same import, from George Baker, "One of her Majestie's chief Chirurgeons in ordinarie" and Master of the Chirurgeons of the City of London.

Then a dedication to the courteous and well willing reader by John Gerrard himself, written from his house in Holborn within the suburbs of London, the first of December, 1597. After this again thirteen folio pages of the history of herbs and materia medica and great herbalists from Solomon downwards, by Thomas Johnson the editor of this edition, a history full of quaint humour but too long for quotation.

Then a catalogue of additions by Johnson to the o iginal work by Gerrard, and so finally after six prefaces, five poems, and a history of plant literature the Herball itself gets under weigh.

Let me again remind you before quoting any medical opinions of Gerrard the time and place of the writing Gerrard's Herball was published a completed book in 1597, nineteen years before Harvey began first to have some idea in his own mind of the circulation of the blood, thirty-one years before he published that most important discovery in medicine in 1628.

The College of Physicians did not publish the first British Pharmacopœia till 1618, twenty-one years after the completion of this book, so there was no definite authority to quote, none to whom Gerrard might refer, only his own erudition and the opinions expressed by his London and country colleagues, quoted throughout the substance of the book. Needless to say, medical pathology and much more physiology was unknown and symptoms only are mentioned and treated; the most important symptoms were those connected with the alimentary and genito-urinary tract, though most plants had some virtues in gynæcology. Heart disease as such was unknown, though its great symptom, dropsy, was treated with a multitude of herbs; for example, in the treatment of this condition you might take your choice of—The round salt marsh reed, the flour de luce or iris, barley meal, squill, garlick, tobacco, dock leaves, plantains, hellebore, castor oil seeds, pennywort, sea navel wort, centaury, hedge hyssop, costmarie or alecoast, the lavender leaved polium, wild margerome, sage, hazel wort, the small mountain bindweed, bryony, tartar emetic, wild cucumber, the black hellebore of Dioscorides, goutwort or bastard pellitory, asafœtida, parsley, wild carrots, fennel, anise, sea wormwood, Carolina thistle, bastard saffron, stinking trefoile, rue, broome, bay leaves, dwarf elderberries, green figs, sassafras, tamarind, guiacum and ginger. Here is a list indeed which for diversity and resource might well turn the budding house-physician green with envy.

I think in the comprehensive nature of these remedies you have the keynote to the interest of the whole book; such surprising cures are effected by the most insignificant of plants that their very contrast tickles your fancy, especially when the virtues of these plants are gravely set down with the authority of ages, from Hippocrates to Dr. Browne "the Queen's physitian."

The contrast between the value set on plants in these days and their place in our therapeutic catalogues is very marked at times. To select at random, for example, digitalis and tobacco; now digitalis is one of the most valuable drugs in our pharmacopœia, and tobacco has just made its exit as a therapeutic agent! Contrast this with the following statements:—

"The Foxgloves in that they are bitter, are hot and drie, with a certain kind of cleansing qualitie joined therewith, yet are they of no use, neither have they any place among medicines, according to the Antients." Here, however, Gerrard somewhat relents from these sweeping assertions and qualifies himself. "Foxglove boiled in water or wine and drunken doth cut and consume the thick toughnesse of grosse and slimie flegme and naughtie humours; it openeth the stopping of the liver, spleene and of other inward parts.

"The same taken in like manner or boiled with honied water or sugar doth scoure and clense the brest ripeneth and bringeth forth tough and clammie flegm. They serve the same purpose whereunto Gentian doth tend, and hath been used instead thereof as Galen saith.

"Now for Tobacco,

"(A.) Nicolaus Monardis saith that the leaves hereof are a remedy for the paine in the head called the Megrim or Migraine that hath been of long continuance; and also for a cold stomach especially in children and that it is good against the paines in the kidnies.

"(B.) It is a present remedie against the fits of the mother; it mitigateth the paine of the gout if it be roasted in hot embers and applied to the grieved part.

"(C.) It is likewise a remedie for the tooth ache, if the teeth and gums be rubbed with a linnen cloth dipped in the juice, and afterwards a round ball of the leaves laid unto the place.

"(D.) The juice boiled with sugar in form of a syrrup and inwardly taken driveth forth the worms of the bellie, if withal a leaf be laid to the navell.

"(E.) The same doth likewise scoure and clense old and rotten ulcers and bringeth them to perfect digestion, as the same author affirmeth.

"(F.) In the low countries it is used against scabbes and filthinesse of the skin and for the cure of wounds, but some hold opinion that it is to be used but only to hot and strong bodies, for they say that the use is not safe in weake and old folkes and for this cause, as it

seemeth, the women in America (as Thevet sayth) abstayne from the herb Tobacco and in no wise use it.

"(G.) The weight of foure ounces of the juice hereof drunke purgeth both upwards and downwards and procureth after a long and sound sleep, as we have learned of a friend by observation, affirming that a strong countryman of middle age having a dropsie tooke of it and being wakened out of his sleep, called for meate and drink and after that became perfectly well.

"(H.) Moreover the same man reported, that he had cured many countriemen of agues with the distilled water of the leaves drunke a little while before the fit.

"(I.) Likewise there is an oile to be taken out of the leaves that healeth merry galls kibed heels and such like.

"(K.) It is good against poison and taketh away the malignitie thereof if the juyce be given to drink or the wounds made by venomous beasts be washed therewith.

"(L.) The dried leaves are used to be taken in a pipe set on fire and sucked into the stomach and thrust forth again through the nostrils against the pains of the head, rheumes, aches in any part of the body whereofsoever they originally proceed, whether from France, Spaine, Italie, Indies, or from our familiar and best known diseases; those leaves doe palliate or ease for a time but never performe any cure absolutely; for although they emptie the bodye of humours yet the cause of the griefe cannot be so taken away. But some have learned this principle, that repletion requireth evacuation, that is fullness craveth emptiness and by evacuation assure themselves of health. But this doth not take away with it this day but the next bringeth with it more; as for example a well doth never yield such store of water as when it is most drawn and emptied. Myself speak by proofe, who have cured of that infectious disease a great many, divers of which have covered or kept under the sickness by the helpe of Tobacco as they thought, yet in the end have been constrained to have unto such an hard knot, a crabbed wedge, or else had utterly perished.

"(M.) Some used to drinke it (as it is tearmed) for wantonness or rather custome and cannot forbear it, no, not in the midst of their dinner, which kind of taking is unwholesome and very dangerous, although to take it seldom and that physically is to be tolerated and may do some good; but I commend the syrrup above this fume or smokie medicine.

"(N.) It is taken of some physically in a pipe for that purpose once in a day at the most and that in the morning fasting against paines in the head, stomache and grief in the brest and lungs, against catarrhes and rheumes and such as have gotten cold and hoarsenesse.

"(O.) Some have reported that it little prevaileth against an hot disease and that it profiteth an hot complexion nothing at all; but experience hath not showed it to be injurious to either.

"(P.) They that have seen the proof thereof have credibly reported that when the Moores and Indians have fainted either for want of food or rest, this hath been a present remedie unto them to supply the one and to help them to the other.

"(Q.) The priests and enchanters of the hot countries do take the fume thereof until they be drunk that after they have been dead three or foure houres they may tell the people what wonders and visions they have seen, and so give them a prophetical direction or foretelling (if we may trust the Devill) of the successe of their businesse.

"(R.) The juice or distilled water of the first kind is very good against catarrhes, the dizziness of the head and rheumes that fall down upon the eyes against the paine called the megrim, if either you applie it unto the temples or take one or two greene leaves or a drie leaf moistened in wine and dried cunningly upon the embers and applied thereto.

"(S.) It cleareth the sight and taketh away the webs and spots thereof, being anointed with the juice blood-warm.

"(T.) The oile or juice dropped into the eares is good against deafness, a cloth dipped in the same and laid upon the face taketh away the same lentills, redness and spots thereof.

"(V.) Many notable medicines are made hereof against the old and inveterate cough, against asthmaticall or pectoral grief, which if I should set down at large would require a peculiar volume.

"(X.) It is also given to such as are accustomed to swoone, and are troubled with the collicke and windinesse, against the dropsie, the worms in children, the piles and the sciatica.

"(Y.) It is used in outward medicines either the herbe boiled with oile, waxe rosin and turpentine, as before set down in yellow henbane, or the extraction thereof with salt oile, balsame, the distilled water of such like, against tumours, imposthumes, old ulcers of hard curation, botches, scabbes, stinging with nettles, carbuncles, poisoned arrows and wounds made with gunnes or any other weapon.

"(Z.) It is excellent good in burnings and scaldings with fire, water, oile, lightning or such like, boiled with Hogge's grease in form of an ointment, which I have often found most true, adding a little of the juice of the thorn apple leaves spreading it upon a cloth and so applying it.

"(A.) I doe make hereof an excellent balsame to cure deep wounds and ulcers and punctures, made by some narrow pointed weapon. Which balsame doth bring up the flesh from the bottom very speedily and also heals simple cuts in the flesh according to first intention, that is to glew or soder the lips of the wound, not procuring matter or corruption into it, as is commonly seene in the healing of wounds. The receit is this. [I think we might have some in the operating theatre.] Take oile of roses, oile of St. John's wort of either one pint; the leaves of tabacco stamped small in a mortar two pounds, boile them together to the consumption of the juice: straine it and put it to the fire again, adding thereto of Venice turpentine two ounces, of olibanum and mastiche of either half an ounce in most fine and subtill powder, the which you may at all times make an unguent or salve by putting thereto wax and rosin

to give it a stiffe body, which worketh exceedingly well in maligne and virulent ulcers as in wounds and punctures. I send this jewell unto you women of all sorts, especially to such as cure and help the poor and impotent of your Country without reward. But unto the beggarly rabble of witches charmers and such like couseners, that regard more to get money than to help for charitie I wish these few medicines far from their understanding and from those deceivers whom I wish to be ignorant herein. But courteous gentlewomen, I may not for the malice that I doe bear unto such hide anything from you of such importance; and therefore take one more that followeth wherewith I have done very many and good cures; although of small cost, but regard it not less for that cause.

"Take the leaves of Tabaco two pound, hogges grease one pound, stamp the herbes small in a stone morter putting thereto a small cup of red or claret wine; stir them well together cover the morter from filth and so let it rest until the morning; then put it to the fire and let it boile gently continually stirring it untill the consumption of the wine, straine it and set it to the fire againe, putting thereto the juice of one pound, of Venice turpentine four ounces, boile them together to the consumption of the juice, then adde thereto the roots of the round Aristolochia or Birth wort in most fine powder two ounces. Sufficient waxe to give it a body, the which keep for thy poor wounded neighbour, as also the old and filthy ulcers of the legs and other parts of such as have neede of helpe."

Here indeed is a panacea for all ills; nowadays even the most confirmed smoker would hesitate to advertise such a list of virtues for his favourite weed. Nevertheless, however low, as in this instance, tobacco has fallen from its high estate, many plants are still kept in the pharmacopœia, and have the same use as they did in the time of Elizabeth. For example, colchicum in all its species is noted in this Herball for its effect upon gout, and gout alone, with a note of warning concerning its occasional purgative properties.

"The pouder of Ginger, long pepper, Anise Seed or Cumine or a little mastick correcteth the churlish working of that Hermodactyl (Colchicum) which is used in Shops. But those which have eaten of the common meadow Saffron must drinke the milke of a cow or else death presently ensueth."

Squill is also highly praised in the form of an Oxymel to "cut thicke tough and clammy humours in chronic coughs, or as a diuretic in various forms of dropsy."

Other drugs, again, like opium, were not held in much respect by Gerrard; he values opium for its power of sending people to sleep, but in general he is rather hostile to its use. He says, "It mitigateth all kinds of paines but it leaveth behinde it oftentimes a mischiefe worse than the disease itself and hard to be cured, such as a dead palsie and such like.

"The use of it as Galen in his eleventh booke of medicines according to the place affected saith is so offensive to the firme and solid parts of the body as that they need afterwards to be restored.

"So also colliries or eie medicines made with *Opium* have beene hurtfull to many; insomuch that they have weakened the eies and dulled the sight of those that have used it; whatsoever is compounded of Opium to mitigate the extreme paines of the eares bringeth hardnesse of hearing.

"Wherefore all those medicines and compounds are to be shunned that are to be made of Opium and are not to be used but in extreme necessitie; and that is when no other mitigater or asswager of paine doth anything prevaile, as Galen in his third book of Medicines, according to the places affected doth evidently declare."

A herb that has evidently been strangely neglected in medicine of late is the common dock leaf or Monk's Rhubarb, according to Gerrard a most potent drug, as witness the following:—

"The leaves of the garden docke or Patience may be eaten and are somewhat cold but more moist and have withall a certaine clamminess; by reason thereof they easily and quickly pass through the belly when they are eaten, and Dioscorides writeth that on the Dockes being boiled do mollifie the bellie, which thing also Horace hath noted in his second book of Sermons the fourth Satyre.

"The decoction of the rootes of Monkes Rhubarb is drunk against the bloody flux, and the wambling of the stomach which cometh of choler, and also against the stinging of serpents as Dioscorides writeth.

"It is also good against the spitting of blood, being taken with Acacia (or his succedaneum the dried juice of sloes) as Plinie writeth.

"If you take the roots of Monk's Rhubarb, and red madder, of each half a pound, sena foure ounces, anise seed and licorice of each two ounces, scabiouse and agrimony of each one handful; slice the roots of the Rhubarb, bruise the anise seed and licorice, breake the herbes with your hands and put them in a stone pot called a steane, with four gallons of strong ale to steep or infuse the space of three days, and then drink this liquor as your ordinarie drink for three weeks together at the least, although the longer you take it so much the better; providing in readinesse another steane so prepared that you may have one under another, being alwaies carefull to keep a good diet. It cureth the dropsy, the yellow jaunders, all manner of itch, scabbes, breaking out and manginesse of the whole body; it purifieth the blood from all corruption; prevaileth against the green sickness very greatly, and all oppilations or stoppings; maketh young wenches to looke faire and cherrie like, and bringeth down their tearmes, the stopping whereof hath caused the same."

Gerrard also shows a very keen knowledge of human nature, both in doctors and patients, as is evident from his remarks on Golden Rod.

"Golden Rod provoketh urine, washeth away the stones in the kidnies and expelleth them, and withall bringeth down tough and raw flegmatick humours

sticking in the urine vessels, which now and then do hinder the comming away of the stones, and causeth the gravell or sand which is brittle to be gathered together in one stone. And therefore Arnoldus Villanovanus by good reason hath commended it against the stone and paine of the kidnies. It is extolled above another herb for the stopping of blood in sanguinolent ulcers and bleeding wounds, and hath in times past beene had in greater estimation and regard than in these dayes; for in my remembrance I have knowne the dry herbe which came from beyond the sea sold in Buckler's Bury in London for half a crowne an ounce. But since it was found in Hampstead wood even as it were at our townes end, no man will give halfe a crowne for an hundred-weight of it. Which planely setteth forth our inconstancie and sudden mutabilities, esteeming no longer of any thing how precious soever it be, than whilest it is strange and rare.

"This verifieth our English proverbe 'Far fetcht and deare bought is best for Ladies.'

"Yet it may be more truly said of Phantasticall physitians, who when they have found an approved medicine and perfect remedie neere home against any disease; yet not content therewith they will seeke for a new farther off and by that means many times hurt more than they helpe. Thus much I have spoken to bring these new fangled fellows back again to esteeme better of this admirable plant than they have done, which no doubt hath the same vertue now that it then had, although it grows so neere our owne homes in never so great quantitie."

But I might go on with example after example without number, only time forbids; the curious may find in a copious index a long list of all diseases with references to the drugs that cure them; a commentary on this index would of itself take more time than I have taken this whole evening. Throughout all these remarks and observations of John Gerrard, you will observe a certain seriousness and enthusiasm for medicine which augurs well for his honesty and singleness of purpose. You feel that at any rate, if Gerrard himself has not seen this or that drug act, at least he takes its virtues on the authority of some well known predecessor or colleague. This being so, it is exceedingly sad to find this worthy tripping, nay, even stumbling over an untruth in the very last chapter of the book, a short chapter on the biology of the Barnacle Goose. Here Gerrard solemnly avers that he had seen with his own eyes what we know cannot have existed, and this small departure from the way of truth rather tinges our admiration with sadness for the weakness of his poor human nature.

If you will permit me in these last few minutes I will repeat to you the history of the Barnacle Goose, which, as you know, was popularly supposed to be hatched from the barnacles on rocks and ships' bottoms.

"Of the Goose tree, Barnacle tree or the tree bearing Geese."

(With a veracious wood cut).

"Having travelled from the grasses growing in the bottom of the foamy waters, the woods, and mountains, even unto Libanus itself; and also the sea, and bowels of of the same, we are arrived at the end of our Historie; thinking it not impertinent to the conclusion of the same to end with one of the marvells of this land (we may say of the world). The historie whereof to set forth according to the worthness and raritie thereof, would not only require a large and peculiar volume, but also a deeper search into the bowels of nature, than my intended purpose will suffer me to wade into, my sufficiency also considered; leaving the historie thereof rough hewen, unto some excellent men, learned in the secrets of nature, to be both fined and refined; in the mean space take it as it falleth out, the naked and bare truth though unpolished.

"There are found in the North parts of Scotland and the Islands adjacent called Orchades, certain trees whereon do grow certain shells of a white colour tending to russet, wherein are contained little living creatures, which shells in time of maturitie do open, and out of them grow those little living things, which falling into water do become fowles, which we call Barnacles; in the north of England 'Brant geese'; and in Lancashire 'Tree geese': but the other that do fall upon the land perish and come to nothing. Thus much by the writings of others and also from the mouths of people of those parts which may very well accord with truth.

"But what our eyes have seen and our hands have touched we shall declare. There is a small island in Lancashire called the 'Pile of Foulders' wherein are found the broken pieces of old and bruised ships, some whereof have been cast thither by shipwracke, and also the trunks and bodies with the branches of old and rotten trees, cast up there likewise; whereon is found a certain spume or froth that in time breedeth into certain shells, in shape like those of the Muskle, but shaped pointed and of a whitish colour; wherein is contained a thing in forme like a lace of silke finely woven as it were together, of a whitish colour, one end whereof is fastened into the inside of the shell, even as the fish of Oisters and Muskles are: the other end is made fast unto the belly of a rude masse or lumpe, which in time cometh to the shape and form of a Bird: when it is perfectly formed the shell gapeth open and the first thing that appeareth is the aforesaid lace or string; next come the legs of the bird hanging out and as it groweth greater it openeth the shell by degrees, till at length it is all come forth and hangeth only by the bill; in short space after it cometh to full maturity and falleth into the sea, where it gathereth feathers and groweth to a fowle bigger than a mallard and lesser than a goose, having black legs and a bill or beake and feathers black and white sported in such manner as is our magpie, called in some places a Pie-annet, which the people of Lancashire call by no other name than a tree Goose; which place aforesaid and on those parts adjoining do so much abound therewith, that one of the best is bought for threepence. For the truth hereof, if any doubt, may it please them to repair unto me and I shall satisfie them by the testimony of good witnesses. Moreover it should seem that there is another

sort hereof; the historie of which is true and of mine own knowledge; for travelling upon the shore of our English coast between Dover and Rumney I found the trunke of an old rotten tree, which (with some keep that I procured by Fishermen's wives that were there attending their husbands return from the sea) we drew out of the water upon dry land; upon this rotten tree I found growing many thousands of long crimson bladders, in shape like unto puddings newly filled before they bee sodden which were very cleere and shining; at the nether end whereof did grow a shell fish, fashioned like a small muskle, but much whiter, resembling a shell fish that groweth upon the rocks about Garnsey and Garsey (Jersey) called a lympet; many of these shells I brought with me to London, which after I had opened I found in them living things without form or shape; in others which had nearer come to ripeness I found living things that were very naked in shape like a bird; in others the Birds were covered with soft downe, the shells halfe open and the Bird ready to fall out, which no doubt were the fowles called Barnakles.

"I dare not absolutely avouch every circumstance of the first part of the story concerning the tree that beareth those buds aforesaid, but will leave to a further consideration; howbeit that which I have seen with mine eyes and handled with mine hands, I dare confidently avouch and boldly put down for veritie. Now if any will object that this tree which I saw might be one of those before mentioned, which either by the waves of the sea or some violent wind had been overturned as many other trees are; or that any trees falling into those seas about the Orchades, will of themselves bear the like fowles, by reason of those seas and waters, these being so probable conjectures and likely to be true, I may not without prejudice gainsay or indeavour to confute.

"And thus having (as Gerrard says) through God's assistance discoursed somewhat at large of Grasses, Herbes, Shrubs, Trees and Mosses, and certain excresences as of the earth with other things more incident to the historie thereof, we conclude and end our present volume, with this wonder of England.

"For the which God's name be ever honoured and praised."

[THE END.]

Nursing News.

MATRON'S OFFICE.

There is no event concerning the nurses to chronicle this week. The Matron has just returned from a short holiday which she spent at Torquay. While we were rejoicing in rain and mud here, the weather at Torquay was fortunately all that could be desired. The blue sky was reflected in the sea, the birds and butterflies forgot it was November, and many summer flowers were in bloom. It was altogether a real holiday, and we are glad to see our Matron back so much refreshed by her short rest.

Two Clinical Notes:

COMMENTS INVITED.

I. FITS INWARDLY.—A country woman's healthy-looking child, aged 10 weeks, died suddenly whilst she was in a clothier's shop. Fortified with "boiley" (bread-crumb and boiled milk) in the forenoon, the child "twisted" and cried, and was given the breast at 12.45, and again at 2.15. Five minutes later, the mother noticed a pink froth issuing from the nose, and exclaimed at once "My child is dead," so that death appears to have been instantaneous.

On arrival, five minutes later, the child was quite dead, and the bowels had acted. The features and extremities were white and not blue, as would have been expected if asphyxia had been the immediate cause of death. No history of any previous fit either convulsive or asphyxial could be obtained, though the mother once consulted a neighbour about the child, and was assured that there was nothing wrong with it.

A slight "peff" (*i.e.* cough) was the only ailment admitted.

In the absence of a post-mortem death appeared due to the reflex effects of stomach-ache, directly prejudicial to some vital centre in the brain, somewhat unsatisfactorily termed, for the information of the jury, an "inward or internal convulsion." Such a mode of death is alluded to by Ashby and Wright (*Diseases of Children, 1899*, p. 536) as "appearing to take place through the nervous system, before asphyxia takes place."

II RECOGNITION OF THE SAC IN HERNIOTOMY.—History shows that the total failure of one's first case (eighteen inches of bowel strangulated in an umbilical hernia of twenty-two years' duration in a fat and intemperate woman) need not deter one from attacking the next.

An old sailor of 75, previously under treatment for aortic disease, bronchitis, and general dropsy, got an inguinal hernia down and strangulated, with the usual symptoms. These were not relieved by the dose of "salts" (about enough to purge a cow) administered by himself. Taxis, etc., failing, operation was undertaken with the aid of A.C.E. and then $CHCl_3$, about thirteen hours after strangulation is supposed to have occurred.

The hernia proved direct, as the deep epigastric artery was felt beating immediately external to the neck of the hernia, and avoided. The aperture was exceedingly small, barely admitting the tip of the little finger. No doubt in cases of longer duration it may become "relatively very large" as Mr. Treves states (*System of Surgery, II.*, p. 722). The sac and fatty coverings, stitched together after reducing the bowel, suppurated and tried to slough, thus prolonging the patient's complete recovery to nearly four weeks, to the infinite advantage of his heart and lung troubles; not a surprising fact considering the almost hopeless difficulties of operating at midnight in a tiny house, with the patient semi-conscious and resisting for all he was worth.

The *real difficulty* was in the imperfect light to distinguish sac from bowel, as the bowel could be seen shining, either naked, or (?) covered by an excessively thin layer of something. Dissection was carried as far as ever one dared, and then the areolar tissue stitched to skin on each side so as to form an artificial anus if wound of bowel could not be avoided. The remaining layer was then successfully incised revealing uninjured bowel and a little fluid.

A remark which fell from the kindly old country surgeon (a veritable MacLure) who assisted me, suggested to me a possible way out of the difficulty in a similar case. It is this; having got as near the bowel as one dares by ordinary dissection, so that it is seen shining either naked (?) or covered by an excessively thin layer, the final plunge if made *right away from* the visible bowel, say below it, will probably release the contained fluid with much less prospect of injury to bowel, and the sac once opened is easily dealt with.

I have thought this point worth drawing attention to, as I cannot find mention of it in several books consulted on the subject. Of course if one can pinch up a fold of sac and coverings in finger and thumb and demonstrate its freedom from the contained bowel, no better evidence is required, but this manœuvre cannot always be practised, and in any case it seems a good rule to open the sac as far away from the contained bowel as possible.

Whitby, Yorks. A. J. SHARP.

Sub-mucous Intestinal Gas Cysts in a Case of Vomiting & Abdominal Pain.

A paper by Dr. Welch, in the September number of the Bulletin of the "Johns Hopkin's Hospital Reports," has led me to think that the following brief note may be of some interest to workers at Guy's, where, I believe, I am right in thinking some interest has been taken in the bacillus ærogenes capsulatus.

An old woman, aged 78, admitted into the Bristol Royal Infirmary, June 8th, 1900, with a fractured femur, was taken in the middle of the night of July 11th with abdominal pain and vomiting. The abdomen became distended, and later in the day she was given a turpentine enema, which acted freely. She died sixteen hours after the onset of abdominal pain.

At the necropsy, sixteen hours after death, nothing noteworthy was found in any of the organs with the exception of the small intestine. The upper part of the jejunum presented the following appearance. Thoughout about twelve feet of its length, the mucous membrane was irregularly raised from the subjacent coats by gaseous distension of the sub-mucous tissues. The distension commenced somewhat abruptly, a few inches below the junction of the duodenum and jejunum, but towards the ileum grew gradually less. The patches of distension became smaller and more isolated, while the cysts of mucous membrane formed by the distension also decreased from the size of marbles to minute bubbles.

Although familiar with post-mortem emphysema of the liver, I had not previously met with this condition of the intestine. Yet the possibility of the bacillus ærogenes capsulatus having been the cause of the gaseous cysts, occurred to me, and I suggested to those present that it might even have been responsible for the death of the patient. Owing to a combination of circumstances, however, cultures were unfortunately not taken by our bacteriologist, an omission I have especially regretted after reading the paper by Dr. Welch, mentioned above. Dr. Welch refers to investigations of his own, and those of others, which show that, although the bacillus ærogenes capsulatus appears to be very frequently present in the normal contents of the intestine under certain circumstances it may give rise to gaseous cysts in the intestinal wall. It is also considered that it may sometimes be the cause of meteorism. In this case, meteorism, associated with abdominal pain and vomiting, resulted in death in the course of a few hours. The woman, though old, was apparently well at the time of onset, and was to have left the infirmary in the course of a few days. Some form of infection was the most reasonable explanation of death, and the presence of gaseous cysts suggests the bacillus ærogenes capsulatus.

If this bacillus commonly occurs in the intestine, it is strange that we do not more often see naked-eye manifestations of its presence. As with other bacilli there must be some conditions which favour its activity. It is a curious fact, perhaps more than a mere coincidence, that by far the two best examples of post-mortem emphysema of the liver I have met with occurred on the same afternoon. THEODORE FISHER.

NOTE.—I regret to say that through inexplicable oversight I had not noticed the paper by Dr. Bryant and Mr. Pakes in the Guy's Hospital Reports, when I wrote the above short account of a case with gaseous cysts in the small intestine, and I now notice that Dr. Bryant and Mr. Pakes consider the bacillus coli communis to be probably the most important micro-organism concerned in the production of gaseous cysts. In connection with the question of the entrance before death into the circulation of gas-forming micro-organisms, I should like to have referred to a case which was under my care as an out-patient at the Bristol Children's Hospital last year, but since it was admitted later into the hospital under the care of an in-patient physician, I hardly feel at liberty to do so. It may be mentioned, however, that a girl aged four years was brought up for wasting of nine months' duration, for which no ordinary cause could be found. She was admitted after attending as an out-patient for three months at the hospital. Six weeks before death, subcutaneous emphysema was discovered by the registrar, Dr. Neild, in the lower dorsal region. At the post-mortem examination no gross lesion was found that could account for death. It may be of interest to add that the mother attributed the illness to the drinking, by the child, of a glass of water in which flowers had been standing for some days.

Passim.

THE Memorial Fund is not progressing at the rate that we should wish. The nature of the object for which we ask subscriptions is such that it must appeal to every man who has learnt to love the old Hospital, and in this category we must include every past and present student of the School. But in order that we may have a fitting testimony to those men who have exemplified the highest ideals of the medical profession, a sum of at least three hundred pounds is necessary. To anyone conversant with the Guy's public, it is a decided fact that we shall get the sum and more if we have only sufficient patience to wait for the slow reaction of purse to brain. But in this case we feel that an early and prompt reply is an essential element in the motive of the memorial. We do not want a long drawn out, to-be-continued-in-our-next species of subscription list; we want rather a short and satisfactory reply to our appeal, that will enable us to close the subscription list promptly and immediately decide on the final purport of the money. We should have something tangible, something definite, when our men come back from Africa, and with that idea we emphatically state that there is no time to lose.

So far, the men actually engaged at the Hospital have shown little or no tendency to support a project of which they all have given approbation. There is always a feeling that one would rather wait and see what the others are doing; but this feeling is damning if no one has the pluck to act for himself. We have said before that no limit, either way, has been put upon the amount that may be subscribed. Half-a-crown, five shillings, and so on, according to the purse; send the money by post, put it in an envelope with name or initials and leave it at the Office of the Secretary to the Treasurer, or with the Librarian; the ways are many and must be left to the ingenuity of the donor. But, and this is the important clause, the response must be immediate. Many men intend to subscribe, many have already promised subscriptions, and with a happy realization of the urgency of the case, we hope these many, with the others, will put their good intentions into some concrete form. *Bis dat*—but the quotation is too hackneyed.

ON another page will be found the text of an alteration in Rule VI. of the Clubs' Union, the true inwardness of which may not be apparent to the casual reader. Under the existing rule the Council consists of six members of the staff and six students, and this Council elects from among its members a president, treasurer, secretary, and assistant-secretary. The president discharges the usual functions of a chairman at sessions of the Council, and the other officials perform the duties usually associated with their offices. By the new rule, which will be confirmed, if no opposition be raised, at the next meeting of the Council, the position and title now contained in the office of president, will be transferred to the similarly elected chairman, and in this respect the Council will be constituted as heretofore. In addition, however, a president, and if the Council deem it advisable, vice-presidents will be elected at the same meeting, and these offices will be filled by not necessarily members of the Council. By this means, the Clubs' Union will be enabled to bestow the honourable title of president or vice-president on patrons and others whose interest in the well-being of the Clubs' Union has not previously been acknowledged by representation on its senate. The rule seems to us, in this respect, to be extremely good and worthy of all support.

THE Smoking Concert of last Saturday was on the whole as successful as most smoking concerts can ever hope to be. The nature of the entertainment is not calculated to bring out the highest attainments of contemporary musical genius, but if the end-all of a concert is to satisfy the audience, then was this concert justified in its end. The rowdy element which is far too frequently associated with smoking concerts everywhere in this country, was kept well under restraint by the indescribable magnetism of the Chairman, and the performers generally succeeded in shaping their talents to their listeners. The financial result of the evening has not yet reached us, but we hope that it will be gratifying to those who had the labour and anxiety of engineering the evening.

MR. CHRISTOPHER HEATH sends us a long letter in which he claims the support of the younger members of the medical profession on behalf of the *Society for the Relief of the Widows and Orphans of Medical Men*, 11, Chandos Street, Cavendish Square. This society, as is sufficiently indicated by its comprehensive title, aims at the financial relief of the immediate sufferers when the breadwinner dies without leaving provision for his family. For instance, the widow of a member of this society, who has

no certain income exceeding in all the yearly value of £80, is eligible to receive a grant not exceeding £50 per annum, and an additional grant for each child under sixteen; but the father must have been a member for three years immediately preceding his decease. Membership is confined to registered practitioners residing within twenty miles of Charing Cross *at the time of their election*, but there is no restriction as to subsequent residence.

THE subscription is two guineas annually for twenty-five years only, or thirty guineas in one payment, but a member whose age at the time of his election does not exceed thirty years may become a life member on payment of twenty guineas, or if under forty years of twenty-five guineas. The point which is especially worthy of the notice of those recently qualified is that, while still resident in London at their several hospitals, they can on payment of twenty guineas make a perfectly secure provision for a possible widow and orphans, and will at the same time aid those who may not be so fortunate as themselves.

DR. JOHN F. J. SYKES, of this hospital, has been awarded the Howard Medal of the Royal Statistical Society, for his essay upon the Housing of the Working Classes. Dr. Sykes' paper has not yet been published, but judging from a speech which is roughly on the same lines as his prize essay, and which was delivered by him at a conference of the Sanitary Institute, it promises to be an important contribution to the literature of this much debated and vexed question.

WE regret to record the death of Dr. Denis Embleton, a well-known medical practitioner and naturalist, of Newcastle. Born in this town in 1810, Dr. Embleton received his medical education at the then joint hospitals of Guy's and St. Thomas. He received a Doctorate in Medicine at Durham University, and also at the University of Pisa, and later, was elected Fellow of the Royal College of Physicians of London. On the consulting staff of the Infirmary at Newcastle, and occupying the chair of medicine at his University, Dr. Embleton was a keen antiquarian as well as an eminent physician, and has left a number of writings on general scientific subjects, in addition to papers on strictly medical matters. Dr. Embleton always maintained an interest in his old hospital, and at the time of his death was a member of our Clubs' Union. His loss will be deplored by all who had the privilege of his friendship, and his death has severed one more link with the past.

APPLICATIONS are invited for the post of Assistant Dental Surgeon, rendered vacant by the resignation of Mr. Baker. Intending candidates should send their applications to the Treasurer of Guy's Hospital, Superintendent's Office, before Thursday, the 29th inst.

IN another column will be found a letter respecting the meals at present associated with the Dressers' Room. It is probably news to men of ten years ago that the bread and cheese and beer which were provided in the rooms in their time have gradually given place to an elaboration of edibles which costs the dressers for the week at least ten pounds. Tea in the old days was the feast of the externs, but it now finds in addition a regular place in the calendar of the dressers. As Mr. Forsyth points out, the difficulty in reform lies in the difficulty in combating the stony conservatism of custom, and an additional obstacle is thrown in the paths of possible reformers by the unavoidable danger that those best qualified to object, namely, the present dressers, may run the risk of suspicions of meanness. The average man cannot afford, in addition to his many expenses, the additional burden of a "take-in." At the same time, he is unwilling to face the awkward position in which any objection raised by him must inevitably place him. Mr. Forsyth's letter, therefore, should be given due consideration by everyone who cares to think for himself, and he is to be congratulated on having the courage to break the silence of so many years.

THERE is one point in connection with the dressers' room that has of late years apparently been considered only of historical interest. The room is the sitting-room of the two dressers for the week. Its privileges are naturally extended to the colleagues of these officials during their week of power, and by tacit consent to the dressers on the other firms. But there the obligation ceases. Everybody else who finds himself in the dressers' room is there as the guest, or by the courtesy, of the dressers for the week. Ward-clerks, medical or surgical, and assistant-surgeons' dressers are there only in the same way that they may be present in the private sitting-room of a friend in the college. The dressers' room is not a common room; no more so than

the externs', the clinicals', and the charities' rooms are common rooms, and it is only fair to the dressers to insist upon this statement of fact. The hospitality of Guy's men is proverbial, but that is no reason why it should be abused.

Some time back we chronicled briefly the capture of Surgeon Fry and his orderly, A. Moon, both of this hospital, by the Boers near Warmsbaths. The following extracts from a letter received from the Colonel commanding the 9th Battalion Imperial Yeomanry will show both the nature of the mishap, and also the character of our brother Boer.

> "On September 3rd, at Buiskop near Warmsbaths, he went out with my 49th Company, who were received with a warm fire, several men were down, one of whom, Harmer Jones, was having his leg bound up by Fry when the Boers began firing at him. He took the brassard off his arm when they advanced and waved it; they then fired all the more, so he put it in his pocket. They then surrounded him and marched him off to the Commandant, one Vorster. This Vorster then said that Fry was a spy, and that he should put him over the border at Koomati Poort. How he proposed to do so I don't know, as the railway was in our hands. General Paget, to whom of course the matter was reported, sent a flag of truce to Vorster and said that he (Paget) should hold him responsible personally, for an act contrary to the laws of civilized warfare. Fry's orderly, Moon, was with him, and had his brassard on the whole time; he also is a prisoner."

The Colonel's letter also contains a few choice anecdotes regarding these same Boers and their pretty little ways.

The Debating Society is trying the experiment of a Parliamentary meeting. The skill and force of some of the speakers has long seemed to us to be wasted in the mere pulverisation of individual members, and at last opportunity has been given them to try a fall with the whole Government. After the usual questions and motions, the House will go into committee on some question, and give ample opportunity for the display of forensic powers. A few harmless individuals will receive temporary elevation and will pose as Cabinet Ministers, and at their devoted heads will be hurled the "exuberant verbosity" of the other side. There ought to be some fun.

The M.B. London list this time is not a matter for much congratulation. We certainly hoped that we should have the pleasure of congratulating a fair number of men on the result, but up to the present, so far as the returns are known, only Messrs. Butler, Densham, and Manson, are permitted to wear faces wreathed in smiles. As only the numbers of the successful candidates are published as yet, we have still a faint hope of adding to the pass list, but this hope is only the weak offspring of a sturdy parent wish.

Gazette Christmas Cards will be published on December 1st from the Library; price, half-a-crown a dozen, single copies threepence each.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Taylor.

Mary	39.	Fibroid lung. Mitral stenosis.
	41.	Mitral regurgitation.
	43.	Aortic and mitral stenosis and regurgitation.
	45.	Tubercular kidney. Excision.
	46.	Spurious hæmoptysis.
	48.	Exophthalmic goître.
	50.	Gastric ulcer.
Cot	51.	? Suppurative meningitis.
	56.	Marasmus.
Philip	21.	Tubercular laryngitis.
	23.	Right hemiplegia and aphasia.
	24.	Diabetes mellitus.
	25.	Aortic stenosis and regurgitation, and mitral regurgitation.
	27.	? Enteric fever.
	28.	Mitral stenosis and regurgitation.
	30.	? Cerebral abscess.
	33.	Pleuro-pneumonia.
	34.	Ascites.
	35.	Acute rheumatism. 2nd attack.
	38.	Chorea. Mitral stenosis and regurgitation.
	40.	Aortic regurgitation.

Cases under Dr. Hale White.

Mary	13.	Cerebral tumour.
	14.	Acute osteo-arthritis.
	15.	Mitral regurgitation, Enlarged liver.
	16.	Cerebral tumour. Trephining.
	18.	Mitral stenosis and regurgitation.
	19.	Hysteria.
	21.	Gummatous periostitis of femur. Syphilitic spleen.
	24.	Chorea.
Cot	53.	Lobar pneumonia.
Cot	64.	Post-basal meningitis. Recovery.

PHILIP	1.	Acute nephritis.
	2.	Appendicitis. Operation.
	3.	Cerebral tumour.
	4.	Fibroid lung. Pulmonary-osteo-arthropathy.
	5.	Appendicitis (1st attack).
	6.	Diabetes mellitus.
	7.	Typhoid fever.
	8.	Typhoid fever.
	9.	Carcinoma of Liver.
	10.	Lead poisoning.
	11.	Appendicitis.
	12.	Mitral regurgitation. Right pleuritic effusion.
	13.	Carcinoma of liver. Jaundice.
	14.	? G. P. I.
	17.	Eczema.
	18.	? Epithelioma of œsophagus.
	19.	Typhoid fever.
	20.	Phthisis. Tubercular laryngitis.

CASES UNDER DR. FAWCETT.

MARY	1.	Ascites. Melanuria.
	2.	Rheumatism. Pericarditis.
	3.	Appendicitis.
	5.	Rheumatism.
	6.	Gastric carcinoma.
	7.	Chronic mercurial poisoning.
	8.	Gastric ulcer.
	9.	? Typhoid fever.
	10.	? Congenital heart.
	11.	? Hydatid of liver.
	12	Peripheral neuritis.
Cot	51.	Congenital heart. Broncho-pneumonia.
Cot	52.	Congenital heart.
STEPHEN	1.	Pneumonia.
	3.	Pneumonia. ? Enteric.
	4.	Pneumonia. Mitral disease.
	5.	Tuberculous peritonitis.
	6.	Mitral disease.
	7.	? Phthisis.
	8.	Phthisis.
	9.	Impetigo.
	10.	Chorea. Endocarditis.
	11.	? Lateral sclerosis.
	12.	? Enteric fever.
	13.	Sarcoma of tonsil.
	14.	Enteric fever.
	15.	Miliary tuberculosis.
	16.	Cerebral syphilis.
	17.	? Septicæmia.
	18.	Locomotor ataxy.
	19.	Epilepsy.
	20.	Diabetes.

CASES UNDER DR. BRYANT.

MARY	25.	Phthisis.
	26.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
	27.	Albuminuria with pyrexia.
MARY	28.	Mitral stenosis and regurgitation.
	29.	Pyuria.
	30.	? Carcinoma following gastric ulcer.
	32.	Gastric ulcer.
	34.	Cerebral embolism from mitral stenosis.
	35.	Gastric ulcer.
	36.	Empyema.
	Cot.	Meningitis.
STEPHEN	21.	Enteric.
	23.	Acute rheumatism with endocarditis and pericarditis.
	24.	Pleural effusion.
	25.	Enteric.
	27.	Hemiplegia.
	28.	Malarial spleen. Purpuric rash.
	29.	Sarcoma of lung.
	30.	Mixed nephritis.
	31.	Phthisis and peripheral neuritis.
	32.	Enteric.
	33.	Mitral disease and bronchitis.
	34.	Carcinoma of stomach.
	35.	Acute rheumatism.
	39.	Anæmia.
	40.	Mitral stenosis and regurgitation.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

LYDIA	13.	Fractured femur.
Cot	D.	Imperforate anus. Colotomy.
ASTLEY COOPER	5.	Fractured tibia and fibula.
	6.	Colles' fracture.
	17.	Double fracture of tibia. Displaced tendons.
	23.	Fractured ribs.
JOB	1.	Epithelioma of nipple.
	2.	Gumma of sternum and ribs.
	6.	Strangulated hernia.
	20.	Stricture and enlarged prostate.
	22.	Tuberculous disease of carpus.

CASES UNDER MR. LUCAS.

MARTHA	12.	Scoliosis. ? Hip disease.
LAZARUS	6.	Necrosis of jaw.
	7.	Hammer toes.
	9.	Congenital hernia. Radical operation.

CASES UNDER MR. GOLDING-BIRD.

CORNELIUS	1.	Divided tendons.
	10.	Ruptured urethra.
	15.	Concussion and fractured base.
CHARITY	4.	Prepatellar bursa.
	5.	Sarcoma of antrum and parotid region.
	12.	Carcinoma of rectum.
	16.	Tuberculous glands.
LUKE	10.	Displaced internal semilunar cartilage.
	11.	? Sarcoma of submaxillary region.
	20.	Osteo-arthritis, knee and ankle.

CASES UNDER MR. JACOBSON.

CORNELIUS	4.	Fractured base of skull.
	6.	Fractured sternum.
	19.	Bullet wound of hand.
DORCAS	6.	Fractured base of skull.
	9.	Appendicitis.
	10.	Renal pyuria. ? Cause.
ASTLEY-COOPER	4.	Compound fracture of tibia and fibula.
	30.	Colles' fracture.
NAAMAN	2.	Bilateral ganglion of wrist.
	4.	Disease of antrum. ? Tuberculous.
	11.	Sarcoma of bulb of urethra.
	12.	Tubercular spine and hip. Morrant Baker's cyst of arm.
	15.	Suprapubic hernia.

CASES UNDER MR. SYMONDS.

LYDIA	1.	Enlarged thyroid.
	6.	Enlarged thyroid.
	19.	Osteo-arthritis and inguinal hernia.
PATIENCE	14.	Chronic abscess. Caries of ribs.
JOB	16.	Melanotic sarcoma of finger and glands.
	17.	Nasal spur and polypi.
SAMARITAN	8.	Otitis media.

CASE UNDER MR. LANE.

LYDIA	10.	Ranula.
	13.	Fibro-adenoma of breast.
PATIENCE	Oct.	Old periostitis of tibia.
LAZARUS	8.	Ulnar paralysis.
	14.	Tuberculous knee-joint with sinuses.

CASES UNDER MR. DUNN.

LUKE	4.	Growth of abdominal wall. ? Nature.
CHARITY	19.	Inguinal omental hernia.
	20.	Tuberculous kidney.
PATIENCE	5.	Suppurating glands in neck.

CASES UNDER MR. FRIPP.

DORCAS	Oct D.	Post-pharyngeal abscess.
NAAMAN	—.	Reducible double inguinal hernia.
SAMARITAN	8.	Axillary sinus.
	10.	Suppurating axillary glands.

GARROULD'S RED-CROSS CATALOGUE.—We have received from Messrs. Garrould, of Edgware Road, W., a catalogue of their nursing requisites. Everything that is possibly associated with the art of nursing finds a place in this list, and the mere man finds himself betwixt bewilderment and awe when he learns for the first time that there are no less than six species of bonnets, and ten varieties of caps herein duly scheduled, with short notes on their ætiology and principal variations. The variety indigenous to London Bridge is, apparently the Sister Dora, "made of washing cambric." That is what we thought all along.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

South African Memorial Fund.

DEAR SIR,—I enclose a small subscription to the South African Memorial Fund, and whatever form the memorial may take I am happy to have the opportunity. Many of us have lost very dear friends, and I suppose the commemoration is the primary object, the means adopted to that end being a very secondary consideration.

The committee naturally would wish their efforts to result in something as permanent as possible and little likely to require maintaining at the hands of generations who will have no recollection of the men whose memory we are anxious to honour.

A glass window would be expensive to repair and might well suffer injury by careless workmen or servants. A column in the park would always be at the mercy of the builders' men. A damaged window or a column moved about, to an obscure corner perhaps, would be intolerable. All men have to ascend the stairs of the medical buildings; the landing wall half-way up to Mary is probably as permanent a spot as any in Guy's. It would seem a good idea to let into this wall a brass, facing towards the swing doors, and bearing the names of those lost in South Africa; and this is what I would suggest as fulfilling three important conditions—permancy, safety from injury, and prominence.—Yours faithfully, WALTER H. W. SMITH.

South Norwood, 13th November, 1900.

DEAR SIR,—It has been proposed to erect a memorial that shall be permanently and constantly in touch with Guy's men, and a stained glass window in the College Hall and a granite column in the Park have been suggested.

I beg to suggest that a memorial in the Park would be more in the public view, both of visitors, patients and past and present Guy's men, than one in the Hall. But at the same time, as the Park is constantly in use during the summer, cannot something be devised even better than a granite column? Would it not be more acceptable to erect one or two stone alcoves, like that from the old London Bridge which is always being used, and in it to place a brass tablet with a roll of the men to whom it is erected? In that case I should suggest that the hospital architect be asked to make designs in keeping with the surroundings of the Park, as he has done so admirably in the building now going on in the front quadrangle.

At the same time it would be only in keeping with the traditions of all public institutions to put up a simple tablet in the students' gallery of the chapel amongst those already there to other Guy's heroes who have lost their lives in the pursuit of their profession —I am, Sir, yours very truly, F. E. FREMANTLE.

The Deanery, Ripon.

DEAR SIR,—I beg to enclose cheque towards the South African Memorial Fund. As a former resident at Guy's, and one who is personally interested, I hope the memorial will not be placed in the chapel, which in my time was rarely visited by students, but will, as already advocated, take the form of a monument in the park or a stained glass window in the hall.—Yours truly,

R. H. HUGHES.

12, Lockyer Street, Plymouth.
November 13th, 1900.

SIR,—I have the pleasure to forward you a small donation to the Guy's South African Memorial Fund.

I should like with your permission to make a few remarks as to the way in which the money raised may be spent. In my opinion the memorial should take such a form that it may be a conspicuous object to everyone, man, woman or child, who comes inside the hospital gates. If that suggestion meet with the approval of the subscribers, it follows that the memorial must be some form of monument. There are a number of sites in the hospital, any of which would be suitable for a monument of this character; the front and main quadrangles and the park, for instance; but in each of these positions a monument would have to be on a very considerable scale or it would be dwarfed and made insignificant by surrounding buildings. A large monument means a large expenditure, and so we are brought to what I consider an ideal site for a memorial of this kind—the colonnade.

Now, as to the form of the memorial; in the last year or two I have seen two monuments of this kind, both of which were very beautiful. The first was by Mr. Nelson Dawson, possibly the best of living metal workers. It took the form of a copper plate on which was an embossed inscription with further decoration in enamel. Such a monument, I think, would be quite appropriate to our purpose, and well fitted to withstand the rigours of the Borough atmosphere.

The second monument, shewn at the International Exhibition at Knightsbridge, was a bronze tablet with figure in relief, and was to a young officer who was killed in some Indian border fight. It was the work of Mr. John Tweed, the sculptor who is now working at the memorial to Major Wilson and his comrades for Mr. Rhodes.

Personally, I should prefer the latter form of memorial and, again personally, I should have no hesitation in entrusting its execution to Mr. Tweed, but it is a matter that may well be left for future discussion.

I am afraid I have written at undue length, my excuse must be that I hope the memorial to our men will be the most beautiful we can get, and worthy of them and their deeds.—I am, sir, your obedient servant,

J. H. GIBSON.

The White House,
Lansdowne Road, Cargate, Aldershot.
November 11th, 1900.

Dressers' Suppers.

DEAR SIR,—May I ask space in the GAZETTE to raise a question which is of considerable interest to all here, and one which though often informally discussed among the men themselves, has never led to any solution. I refer to the custom that compels dressers for the week to provide daily meals for all who care to accept their hospitality.

How or when the custom originated I do not know, but in recent times its growth has undoubtedly been considerable, and at the present day it has attained an almost lavish scale. Years ago the supper in the dressers' rooms consisted of some homely fare such as bread and cheese; later, as new dressers succeeded to the office they, naturally enough, added this or that dish until now the cost of these meals amounts to some pounds each week. Tinned fish, joints of meat, preserved fruits, figs, pickles, etc., are expected to be on the table every night, while for tea (which, taken in one's own rooms, would be much simpler) there is an elaborate spread of bread, butter, jam, cakes, biscuits, and so forth. In addition to this the two dressers are expected to provide cigarettes and beer, ad lib., and all day long, for the benefit of every comer, friend or stranger.

The expenses of all this may be nothing to a man with some means, but to many it is of serious proportions, and I believe has more than once deterred a student from applying for an extension of his dressership. Under present circumstances the cost to each dresser is little, if any, under five pounds for the seven days, though it is by no means rare to find even this sum exceeded I have spoken to many men on the subject and they have all agreed with me that such a state is little short of scandalous, yet no one has ever made any effort to reform the matter. Men who have not attained the dignity of full dresser (with its attendant burdens) have given the question no attention, and when the expense is thrust upon them at the advent of their own take-in, they cannot of course protest for fear of incurring accusations of meanness. Later still, when they take their place among the "senior men" and the memory of their dressing days is growing hazy, they are only too apt to regard the suppers either with indifference, or as things to be maintained merely because tradition orders maintenance.

I fully appreciate the fact that reformation may not at first be easy to effect, but if the matter were taken up by the Residents (who have never been behindhand when improvement was needed), its success would be assured. Let, say, the four House-Surgeons (as the most suitable persons concerned) prepare some scheme in solution of the problem, and then call a meeting, not only of their dressers, but of all men in the wards, both senior and junior, to them, where their proposals could be submitted, discussed, amended perhaps, and carried. It would not be necessary or even desirable to abolish the suppers in toto, for men working in the surgery till past midnight need some refreshment before seeking their beds, but let

a strict rule be passed, and be stringently enforced, stating what articles of food are permissible both at supper and tea, and if thought advisable let the custom of providing free cigarettes from morning to night be modified. Lastly, the question of expense must be given consideration. Why should the whole cost of the take-in be on the shoulders of the two unfortunate over-worked dressers for the week? Let each member of the firm pay his share of the bill—the dressers in one proportion, the clerks in another, and so the expense will fall lightly when distributed through many purses.

Trusting that this letter may be the means of adding one more item to the long list of improvements effected by your colums.—I remain, yours truly,

DAVID FORSYTH.

Guy's Hospital, Nov., 20th, 1900.

On Humbug.

For the production of a successful doctor, from a worldly point of view, several diverse characteristics are required: a pleasing presence, an insatiable appetite for work, a certain though small amount of medical knowledge, a large amount of common sense, and last and most important, the faculty of inspiring confidence.

Three or four days of illness are enough to make some men's patients begin to hint at a consultation, while, under the treatment of others, rich and poor, influential and humble will cheerfully submit to long-continued anguish, to deformity and to death without even a thought that their lot might possibly be improved by what is called "further advice." Of what then does this most desirable faculty consist?

It is the resultant of two sets of forces; firstly, certain qualities inherent in the doctor, on which I do not now propose to dwell, and secondly, the credulity of the public.

This credulity, which, be it observed, is shown equally by all classes of the public, has no limits.

It is due in part to their astonishing ignorance, an ignorance natural enough, no doubt, in the uneducated classes, but even the most highly educated people are no better, as we can see any day by reading the articles on medical subjects which now so constantly appear in the daily papers.

When one considers how the public go to doctors, open-mouthed, like geese on a common, asking to be humbugged about their complaints, one wonders that there is a single honest man left in the profession; perhaps if all were known, there are not many.

Which of us who have been in practice for any considerable time can lay his hand on his heart and say he has never talked of "pulling a patient through," of "taking a case in time," or has never allowed grateful patients to ascribe to his treatment a result produced by the ordinary course of nature. We are driven to it. "Our people love to have it so."

Look round and see which of us it is who empties his drug bottles and fills his cash-box. The man who habitually magnifies the seriousness of illness in order to enhance the credit he will get when recovery takes place, who plumps for a diagnosis when none is warranted, who creates chronic invalids out of people who might be healthy useful members of society by a thousand unnecessary fads and restrictions upon their way of life, their food, their drink and their clothing. A friend of mine slipped when playing tennis, and displaced a semilunar cartilage. He was treated by his doctor in the country in the routine way, but, as the joint did not get well as soon as he expected, he went up to see a world-renowned specialist in London, who, after examining the knee, said, with a horrified face, "My dear sir, are you aware that you have been going about ever since the accident with a piece of the membrane of the joint pinched between the bones?" This distressing condition, needless to say, he speedily put right by a little "specialised" manipulation.

Now how can we condemn the poor bone-setter with his story of the "dislocated cup," or the knee which has been "out" so long, when such things as these are said by the heads of our profession.

If no worse mischief were done than the drawing of the unfortunate patient into the toils of the quack, one would not be so inclined to complain, but in this case, as in so many others of the kind, a grave and absolutely unwarranted aspersion is cast on the reputation of a fellow medical man, and cast in such a way, and by such an authority, that there is absolutely no appeal against it.

I am no advocate for allowing professional etiquette to have such claims upon us that we should go any lengths to shield a broken practitioner from the consequences of a mistake, but I can conceive nothing more contemptible than for one of the fortunates of the profession deliberately to injure the reputation of his less successful comrade, for no other reason that I can see than that of self-interest.

The honourable man recognises the immense responsibility imposed upon him by the blind trust with which his words are received, and the paramount necessity for truth and fair dealing in his intercourse with his patients. There is, however, a good side to this credulity. It constitutes, without doubt, a very valuable therapeutic agent, and many a man, I am convinced, has got well through his confidence in his doctor who would have died had he mistrusted him, or had he even been aware how small an influence over the course of his illness the doctor really possessed.

And this raises the question, How far is it possible to retain the confidence of our patients if we absolutely refrain from any form of practising on their credulity? How far is it allowable to do the latter in their interest, and where should we draw the line between their interest and ours as our motive power? It is an obvious argument, in the most common case in which the question arises, that of the rich hypochondriac, that if we speak "the truth, the whole truth," etc., the only result will be the transference of the patient, his symptoms, and his

money-bags, to another, less scrupulous or more therapeutically broad-minded, whichever way you choose to look at it; but the patient's ultimate recovery, or at all events the alleviation of his symptoms, is to be procured perfectly scientifically, on the lines of treating him with a little mental soothing, as we should apply a hot fomentation to a boil, and lastly that that is what he has called us in for and means to get, so why should we not give it as well as another? Again, if we push our professional rectitude to its logical conclusion, what becomes of our belladonna plasters, our placebos in every shape, sanctioned by immemorial usage?

The mind shudders at the spectacle of the humbug-free doctor, stalking through the world, heedless alike of the anxieties of motherhood, the timidity of children, or the morbid fancies of the sick.

The smallest ache or pain which we are called upon to treat, trivial as it appears to us, to the sufferer is more important than anything in the world, and that is a fact which we should never forget.

It is not a very dignified position to be sent for by a rich patient to administer this sort of treatment, but we must remember that while the social position of the medical profession has changed so greatly in the last hundred years, the demands which are made upon it, and the needs which it supplies, are, and always will be, unchanging; and without doubt that very amelioration in our position and our knowledge which we value so justly, has in some ways rendered us less fitted for our work.

Most general practitioners, I should think, must have noticed how often a visit to or from the modern type of consultant leaves the patient in an unsatisfied condition, and the reason is not, I think, far to seek. "Behold" he says, in the words of the earliest of his race, "I thought he will surely come out to me, and stand and call on the name of the Lord his God, and strike his hand over the place." Which would, undeniably, have been a good guinea's worth.

The profession of medicine, however, is gradually being stripped of the mysticism which used to surround it, and which was one of its most valuable remedial agents, but whereas in other sciences, this, the natural result of increasing knowledge, is an unmixed benefit, in medicine, for the reasons I have stated, it is by no means so.

And more; the protean variations of disease, the inexplicable terminations, the bewildering intertwining of diseases of the mind with those of the body, and the almost absolute want of certainty, of due sequence of cause and effect in what we see, all tend to impress upon us that there is, in very truth, a veil which all our science cannot lift, and that life, the object of our care, extends to all its manifestations, healthy and diseased, a portion of that unfathomable mystery with which it is itself enshrouded.

In spite of all our advances in science empiricism still enters largely into our system of therapeutics, and, while we continue to employ mercury in syphilis and salicylates in rheumatism, there can be no reason for our refusing to make use, both in ourselves and our patients, of the personal factor, a therapeutic agent whose mode of action is no less comprehensible and even more potent than theirs. The whole question rests, as do so many of our relations with our patients, on the good faith and honesty of ourselves.

Our position in society is grounded on the assumption that we possess these qualities, and to them and to their results is due the unequalled fascination of the profession to which we are proud to belong. H.

Pass List.

Royal College of Physicians of London, October, 1900.

EXAMINATION FOR THE DIPLOMA OF MEMBER.

John Lloyd Roberts, B.A., M.D. Lond.

Royal College of Surgeons of England.

FINAL L.D.S. EXAMINATION.

(Old Regulations.)

A. W. Aldis, A. Archer, G. H. Aylen, K. Black, S. C. Bowle, F. W. Bromley, H. R. C. Butler, A. C. Carpenter, E. W. Corfe, A. R. Cummings, H. L. Dent, A. Drewitt, N. W. Green, P. Greenwood, C. Hicks, H. N. Hillier, J. J. Jimenez, G. F. Knowles, W. E. Meads, J. Milligan, F. Morris, J. W. Powell, G. W. Ray, H. B. Ross, V. S. Sams, H. R. Shapland, C. R. Shattock, A. H. Smith, T. Walkington, D. H. Wallis, H. J. Webb, H. C. Winckworth, H. S. Wright.

FIRST PROFESSIONAL EXAMINATION.

(New Regulations.)

MECHANICAL DENTISTRY AND DENTAL METALLURGY.—W. E. Griffin, C. Mills, F. R. E. Palmer.

MECHANICAL DENTISTRY ONLY.—J. B. Barron.

DENTAL METALLURGY ONLY.—A. R. Beaumont, H. L. Whitlow, C. D. Wood.

University of London, October, 1900.

M.B. EXAMINATION.

SECOND DIVISION.—J. A. Butler, A. Densham, P. T. Manson.

Notices.

GUY'S HOSPITAL CLUBS' UNION.

In accordance with Rule 23, notice is hereby given of the following alteration to Rule 6, which will be confirmed at the next meeting of the Clubs' Union Council:—

> The Council shall at the first meeting after their appointment elect from their number a Chairman, a Treasurer, a Secretary, and an Assistant Secretary, each to hold office for one year. They shall also elect at the same meeting and for a similar period

a President of the Union, and if they think desirable one or more Vice-Presidents. A President or a Chairman may be elected for a second period of one year, but shall not otherwise be re-eligible till after the expiration of two years from the date of his retirement.

The Rule at present reads:—

The Council shall at the first meeting after their appointment elect annually from their number a President, a Treasurer, a Secretary, and an Assistant Secretary. The same President shall not hold office for more than two consecutive years.

Any objections to the above alteration should be forwarded to the Secretary of Guy's Hospital Clubs' Union within fourteen days from this date.

November 15th, 1900. F. J. STEWARD,
Hon. Sec.

Applications are invited for the post of Assistant Dental Surgeon, vacant by the resignation of Mr. Baker, and should be addressed to the Treasurer, Superintendent's Office, Guy's Hospital, S.E., not later than Thursday, November 29th.

South African Memorial Fund.

(This Fund has for its object the erection of some permanent Memorial in the Hospital to those Guy's men who have fallen in South Africa.)

The following are the names of the Guy's men who have lost their lives in the South African Campaign:—H. A. Bryant, L. J. Hughes, H. Pope-Walker, R. T. Fitzhugh, Stanley Whicher, H. B. Onraët, and Thomas Jones.

SECOND LIST OF SUBSCRIBERS.

	£	s.	d.
Amount already acknowledged...	38	15	6
R. H. Hughes, M.B.	5	5	0
L. A. Dunn, M.S.	3	3	0
F. E. Fremantle, M.B.	2	2	0
P. Horrocks, M.D.	2	2	0
W. H. A. Jacobson, M.Ch.	2	2	0
R. Clement Lucas, B.S.	2	2	0
T. Stevenson, M.D.	2	2	0
Dr. and Mrs. Frederick Taylor...	2	2	0
J. H. Bryant, M.D.	1	1	0
F. K. Butt	1	1	0
J. H. Gibson	1	1	0
A. W. Reinold, F.R.S.	1	1	0
E. Ivens Spriggs, M.D.	1	1	0
J. C. Uhthoff, M.D.	1	1	0
C. H. W.	0	10	6
F. W. S.	0	10	0
G. M. Brown	0	10	0
W. H. M. Smith	0	5	0
	£67	17	0

Sport.

Rugby Football.

GUY'S v. ROYAL ENGINEERS.

(GUY'S, 9 POINTS; ROYAL ENGINEERS, 5 POINTS).

Played at Chatham on Nov. 7th. We went down with a weak team, several of the usual members being absent. Losing the toss we kicked off against a stiff breeze. During the greater part of the first half Guy's were two short in the pack, and with difficulty managed to prevent their opponents scoring, but after the arrival of the late comers, matters became more equal. Half-time was called with nothing scored.

After the interval, Guy's playing with the wind, soon attacked, and after a good bout of passing Wadson scored far out on the left. No goal resulted. Shortly after, a good dribble by Hicks and Thompson resulted in the latter securing a try; the attempt at goal was unsuccessful. Then the Engineers, by a series of loose rushes, carried the ball into our 25, and a subsequent combined movement by their three-quarters enabled them to score far out. Thorp, with a splendid kick, landed a goal. After this, play was confined to our opponents' territory, and some good passing enabled Morgan to get over between the posts. McEvedy took the kick, but failed. Time was called immediately after, leaving Guy's winners by three tries to one goal. Team:—

GUY'S.—E. M. Harrison (back); G. P. Wadson, E. Morgan, G. C. Brown, P. F. McEvedy (three-quarter backs); J. T. Hicks, W. Lindsay Woods (half-backs); A. H. E. Wall, E. H. B. Milsom, A. R. Thompson, R. G. Anderson, B. Glendinning, M. A. Collins, J. E. Hodson, H. Watts (forwards).

GUY'S v. BEDFORD.

(GUY'S, 6 POINTS; BEDFORD, 3 POINTS).

On Saturday, November 17th, the hospital team visited Bedford. The day was anything but an ideal one for football, rain having fallen throughout the morning, though it fortunately held off during play. This, no doubt, accounted for the scrambling nature of the game, the ball being difficult to gather. Bedford won the toss, and kicked off before a fair number of supporters. Play settled down in the home quarter, but Bedford speedily relieved with a series of loose rushes, and the game was for some minutes confined to the hospital territory. Pye-Smith was now conspicuous with a good dribble, and Morgan, backing him up well, gathered the ball and raced down the line. On reaching the back, he passed in to Pye-Smith, who scored in a good position. The try was not converted. On restarting, Bedford became dangerous, but were quickly forced back, and Louisson set the three-quarter line going. McEvedy ran strongly, being tackled only just in time to save a score. These tactics were repeated, but no further score occurred before half-time.

After the interval Guy's attacked strongly, and good passing among all the outsides, resulted in a try by

McEvedy. Following this, play was of the kick and rush character, and in favour of the home side, who were frequently allowed to break through, all attempts at saving being somewhat feeble. Ultimately Bedford scored a penalty goal, and the game ended in a win for Guy's by 6 points to 3. Team:—

GUY'S.—E. M. Harrison (back); E. Morgan, L. C. Brown, A. O'Brien, P. F. McEvedy (three-quarter backs); C. D. Pye-Smith, M. G. Louisson (half-backs); H. A. Cutler, A. H. Wall, R. C. Lawry, R. G. Anderson, A. R. Thompson, B. Glendinning, E. H. B. Milsom, H. Watts (forwards).

GUY'S 2ND XV. v. LEYTONSTONE.

(GUY'S, 19 POINTS; LEYTONSTONE, NIL).

Both teams were very weakly represented, and the game was of a very scrambling nature. Owing to the unchecked off-side play of the opponents' halves, Guy's were unable to get the ball away in anything like form; also the forwards could not be persuaded to get the ball out sharp. At half-time the score stood in Guy's favour by 1 goal, 1 try, to nil.

The second part of the game proved more unequal still, Guy's scoring three times more, so that Guy's won by 2 goals, 3 tries, to nil. Gardner made very good shots at goal. Goals were kicked by Gardner and H. S. Brown. Team:—

GUY'S.—R. D. Bridger (back); E. N. Jupp, S. L. Pallant, H. S. Brown, S. P. Wadson (three-quarters); J. T. Hicks, A. E. Kynaston (halves); N. B. Odgers, H. D. Smart, G. Nunn, R. M. Rendall, B. Moiser, F. A. Beattie, J. T. Gardiner, L. D. Stamp (forwards).

Association Football.

GUY'S 1ST v. REIGATE PRIORY.

(GUY'S, 3 GOALS; REIGATE PRIORY, NIL).

Played at Reigate on the 17th, this match resulted in a win for Guy's by 3–0. Reigate kicked off downhill and had most of the opening play, but after about ten minutes Norton broke away and scored our first goal. Shortly after, Barber added the second, and although several good chances were offered both sides, nothing further was scored before half-time, Collins saving finely on several occasions.

In the second half, with the slope in our favour, we had more of the game, but added only one more goal—a fine shot from Barber. Reigate made several good attempts to score, but our defence, throughout very good, prevailed, and when time was called—ten minutes early on account of the darkness—we were left winners by 3–0. Team:—

GUY'S.—E. A. Collins (goal): A. P. Croft, S. M. Wells (backs); H. Bacon, J. Goss, J. Cameron (halves); T. Edey, H. Barber, T. A. Chignell, E. L. Norton, T. F. Wilson (forwards).

GUY'S 2ND XI. v. CITY OF LONDON SCHOOL.

(GUY'S, 5 GOALS; CITY OF LONDON SCHOOL, 1 GOAL).

This match, played at Honor Oak on Wednesday, October 24th, resulted in a win for the Hospital by 5 goals to 1. The first stages of the game were evenly contested, and the middle of the first half was reached before Roberts scored for the Hospital. Ten minutes later the same player obtained another goal. The City forwards then got away on the right wing, and scored after a scrummage in front of goal. Half-time arrived without any further addition to the score.

During the second half our opponents were never really dangerous, and the Hospital having most of the game scored through Roberts, Bell and Peall.

Leeming, at back, played a very steady game and had rough luck in not scoring from a corner. Brailey was certainly the best of the halves, but all three must learn to feed their forwards. The combination among the forwards was at times good, but the shooting can certainly be improved upon. Roberts and Dent played good games. Team:—

GUY'S.—L. Smalley (goal); A. Leeming, J. Braithwaite (backs); W. Reynolds, G. Brailey, W. Henderson (half-backs); H. L. Dent, A. H. Bell, W. O. Roberts, F. Morris and P. A. Peall (forwards).

Births.

CULMER.—On October 31st, at Chinehurst, Alum Chine Road, Bournemouth, the wife of J. W. Culmer, M.R.C.S., L.R.C.P., of a son.

DU BOULAY.—On November 16th, at 2, Royal Terrace, Weymouth, the wife of H. Houssemayne Du Boulay, of a son.

ENSOR.—On November 2nd, at Tisbury House, Tisbury, Salisbury, the wife of Cecil Arthur Ensor, M.R.C.S., L.R.C.P. Lond., of a daughter, prematurely.

HUDSON.—On November 16th, at Vine House, Cobham, Surrey, the wife of Arthur B. Hudson, M.R.C.S., L.R.C.P. Lond., of a daughter.

PITT.—On the 19th inst., at 15, Portland Place, W., the wife of Dr. G. Newton Pitt, of a son.

WAKEFIELD.—On November 18th, at Lincoln Lodge, Horley, Surrey, the wife of Christopher Frank Wakefield, L.R.C.P. Lond., M.R.C.S., of a daughter.

Marriage.

MARRIOTT—GOCHER.—On November 8th, at the Parish Church, Edgbaston, by the Rev. Horatio Spurrier, M.A., Vicar of Shildon (uncle of the bridegroom), assisted by the Rev. Canon Cresswell Strange, M.A., Vicar of the Parish, Hyde Marriott, B.Sc., M.B. Lond., eldest son of the late Joshua Marriott, of Stockport, to Emily Katharine, third daughter of Thomas Gocher, of Edgbaston. At home December 5th, 6th and 7th. No cards.

Deaths.

COUCH.—On November 6th, at Penzance, John Quilier Couch, M.R.C.S., L.M. Eng., L.S.A. Lond., aged 69 years.

EMBLETON.—On November 12th, at Newcastle-on-Tyne, *Dennis Embleton*, M.D., F.R.C.P., *Consulting* Physician, Royal Infirmary, Newcastle-on-Tyne, aged 90 years.

ED.—S. H.

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Calendar of Coming Events.

December, 1900.

Sat. 8.—Messrs. Jacobson and Fripp's take-in; Drs., D. H. Trail and A. C. H. Gray; Cl., P. W. L. Camps.
1 p.m., Clinical lecture by Dr. Pitt.
Last day for applying to Registrar for Form of Entry for Prelim. Scientific and Intermediate M.B. Lond. Exam.
Application to Med. Sch. Office for Schedules for 1st and 2nd Conjoint Exam. to be made not later than this date.
G.H.R.F.C., I., Croydon, home.
II., Croydon, away.
III., Blackheath School, away.
G.H.A.F.C., I., Surbiton Hill, home.
II., Surbiton Hill 2nd XI., away.
G.H.P.P.S. Paper by Mr. Stanley Hodgson on "Infective Endocarditis."

Mon. 10.—1.15 p.m., Clinical lecture by Mr. Laidlaw Purvis.
Cambridge 1st and 2nd M.B. Exams begin.

Tues. 11.—Cambridge 3rd M.B. Exam. begins.
12 noon, Mr. Rowell's Demonstration on Anæsthetics.

Wed. 12.—1.30 p.m., Clinical lecture by Mr. Howse.
Schedules for Final Conjoint Exam. to be left at the Medical School Office not later than this date.
G.H.R.F.C., II., St. Bart.'s, away.
G.H.A.F.C. I., St. Leonards, away.

Thur. 13.—Messrs. Howse and Symonds' take-in; Drs., D. S. Jackson and F. M. Ommanney; Cl., L. E. Stamm.

Fri. 14.—4 p.m., Meeting of the Dental Society.

Sat. 15.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., I., London Scottish, away.
II., Streatham, away.
III., Catford Bridge II., home.
G.H.A.F.C. I., Old Foresters, home.
II., Croydon Park 2nd XI., away.

Tues. 18.—Exam. in Dental Metallurgy for 1st Year's Prize.
12 noon, Mr. Rowell's Demonstration on Anæsthetics.

Wed. 19.—1.30 p.m., Clinical lecture by Mr. Howse.

Thur. 20.—Messrs. Lucas and Lane's take-in; Drs., M. A. Collins and A. H. E. Wall; Cl., F. W. Sime.
Christmas Exams. for 1st and 2nd Year's Students begin.
Christmas Exams. in Dental Anatomy for 1st and 2nd Year Students.

Fri. 21.—First half of Winter Session ends.

Guy's Hospital Gazette,

DECEMBER 8, 1900.

Acute Intussusception in Children.

CLINICAL LECTURE BY DR. FAWCETT.

July 18th, 1900.

GENTLEMEN,—The subject which I propose to speak about to-day is that of Acute Intussusception in Children, with special reference to three cases I have been called to see lately in the hospital.

The first patient was a child of eleven months who had been ill for sixty hours. I will read you the history of the case: "The child had been always well previously. He was admitted with vomiting, and passing blood and mucus per rectum. He was first taken ill on Thursday afternoon, July 12th, with vomiting. He appeared to be in great pain, and refused his food. A doctor was called in, but could not find anything the matter with the child. The next day the child was in the same condition, and, on July 13th, he began to pass blood and mucus per rectum." Patient was then sent to the hospital, and was seen about twelve o'clock. A description as follows of the condition of the child is given by the clinical assistant, Mr. S. Perkins: "The child lies on his back and is evidently in great pain, as he is crying out, and throwing himself about, and pressing his hands into his abdomen." The child was evidently ill with some abdominal complaint. The temperature was subnormal, 96·6°. "A marked

bulging can be seen in the right iliac fossa extending towards the costal margin. The abdomen moved little on palpation and there is a mass to be felt." Supposing this (diagram drawn on blackboard) to represent the abdomen, there was a tumour in the lower part fading off above (indicated). "It does not alter much in consistence, and is decidedly painful on palpation, the child crying out when the part is touched. On percussion the note over the swelling is impaired. On rectal examination a protrusion can be felt two inches up, which is evidently the apex of an intussusception. It comes lower down when the child strains, and on withdrawing the finger there is blood and mucus on it." These are the chief points in the report.

The two other cases were admitted under Dr. Hale White and Dr. Taylor respectively. The first was a child of five months who had been ill for twelve hours, and the second a child of six months, the duration of whose illness could not be determined exactly, but was certainly less than twelve hours.

Thus, one child had been ill sixty hours, one twelve hours, and one something under twelve hours. In all the three cases the most prominent signs were the passage of *blood and mucus* by the rectum, with the presence of an *abdominal tumour*. In cases of intussusception, the passage of blood and mucus per rectum results, of course, from the engorgement and strangulation of the vessels. Hæmorrhage often takes place into the mucous membrane, and from the surface into the lumen of the bowel, but it does not always do so.

With this passage of blood and mucus per rectum there is commonly *diarrhœa*. Diarrhœa is a frequent symptom in the early stages of intussusception, but when after a time the lumen of the bowel becomes blocked, complete constipation ensues. Even then there may be passage of blood and mucus by the rectum. The diarrhœa which is associated with this discharge, is set up by the violent peristaltic contractions occurring as the result of the strangulation.

With regard to another symptom—*Vomiting*. It was present in two out of the three cases, but is often not a marked feature of the case, and is very seldom excessive in cases of intussusception; sometimes it does not occur at all, so that you must regard it as being a variable symptom.

The next most important point is as to *the mode of the onset*. This is generally sudden; it was so in all three cases, as the reports show. Another point to be remembered with regard to intussusception is, that it may come on when the child is in a perfect condition of health, and this, apparently, happened in all our cases. Frequently, however, there is a previous history of some colic or alimentary canal disturbance.

Now as to the *pain*. This was rather a prominent symptom in the case that I read first, but in the others pain was by no means a striking symptom. Usually it is not so severe as when you have strangulation of the intestine by a band; and the character of the pain, at first at any rate, is that of paroxysmal colic. The patient lies for a few minutes quietly in bed and then begins to cry out. Then the attacks of colic gradually become more frequent, until you get a continuous pain, with exacerbations from time to time. The report says, "that the child was evidently in great pain, as it was continually crying out, and throwing itself about, and pressing its hands into its abdomen." In some forms of intestinal obstruction the pain is a very well-localised one. In intussusception that is not so; the pain is at first very ill-defined.

Another interesting point about intussusception cases is, that at first the abdomen is quite *flaccid*, and is *not tender* under pressure. It is not until you have a localised peritonitis over the tumour, or one spreading from the neighbourhood of the tumour, that the abdomen becomes tender on palpation. For instance, in one of our three cases the abdomen was lax and not tender; it was not like an abdomen in a case of obstruction by a band, or of an acute peritonitis.

Next let us consider the feature of *prostration* or collapse which is often very marked, and is only what you would expect in an acute intestinal obstruction in a small child. The child is usually very collapsed and restless.

You do not get meteorism until the diarrhœa ceases and the obstruction is complete. In other cases of acute intestinal obstruction, as by a band, or a volvulus in adults, this meteorism is a marked feature.

Another sign which was present in all our three cases was a *tumour*. In the first case there was a tumour in the lower part of the abdomen; in another case we felt a tumour in this region (indicated); and in the remaining case we could trace a tumour underneath the left lobe of the liver and near to the spleen. In the third case, therefore, the tumour which we felt was in the upper part of the abdomen, running transversely across it and along the line of the transverse colon. In the

second case, the tumour was along the ascending and transverse colon. And in the first case the tumour was located in the lower portion of the abdominal cavity, over the course of the ascending colon.

Although a tumour was present in all these cases, statistics show that it is not met with in more than half the cases of intussusception, and the most common situation for it is over the transverse and the descending colon. As a rule, the tumour is one that you cannot define very readily, and it varies very much in distinctness. One feature of it is, that it may become firmer with the attacks of abdominal pain, and may move under the influence of an enema. Another point about it is that, if it is large enough, it may be felt per rectum; In one of the cases, you remember, a tumour was felt per rectum; in the other two there was no tumour to be felt there. Of course, it may not be possible to feel an abdominal tumour at all, because the small intestine may be so distended as to cover up the tumour altogether.

The symptoms which I particularly want to draw your attention to in all cases of intussusception in children are, the vomiting, the restlessness, the paroxysmal abdominal pain, the appearance of collapse, and the passage of blood and mucus per rectum. If you have these symptoms in a child, even if there is no tumour, you would, of course, administer chloroform, as you can then palpate the abdomen more completely, and so ascertain the underlying condition. A fact to be remembered with regard to intussusception is that it is *the only common* form of intestinal obstruction in children.

Now as to *the course* of the disease. It occurs most frequently in children under two years, and the largest number of cases are in children under one year old. If you do not relieve the condition by treatment within a period of thirty to forty-eight hours it is almost certain to prove fatal. A spontaneous cure by sloughing in the intussuscepted portion may occur, but that is, unfortunately, a rare result.

The most important point in connection with these cases, after you have made your diagnosis, is the treatment, and therefore I propose to go into it somewhat fully. I will read to you that adopted in the first case. We decided to perform inflation by means of milk and water. We could not get milk and water because all the milk had coagulated. But we decided to use fluid, and I will tell you why presently. The fluid was injected at a temperature of about 100°, the child having first been put under chloroform. For the injection we made use of an ordinary glass funnel, with which was connected some india-rubber tubing, having a vulcanite tube attached to it, and this latter was inserted into the rectum. Suppose that (on blackboard) to represent the handle of the inflator, here is the tube which was inserted into the rectum, and around this tube we placed a hollow perforated indiarubber ring. The nozzle is inserted into the rectum, and the indiarubber ring around forced up against the anal folds and so the fluid prevented from running out of the rectum as soon as it has been injected. By means of the glass funnel and connecting tube we could vary the pressure as we wished, by raising or lowering the height of it above the patient.

We then tried to inject the fluid into the rectum, but the tumour was so firmly fixed by adhesions that it was quite impossible to produce any effect whatever by means of the fluid, and in view of the fact that the child had now been ill sixty hours it was considered quite useless to go on trying to reduce the intussusception by forcing fluid into the bowel. I therefore asked Mr. Dunn to operate.

On opening the abdomen he found a tumour which involved the whole of the descending, transverse, and ascending colon. It was a most difficult intussusception to deal with. Almost the whole of it had to be delivered from the wound. The tumour was fairly readily reduced in the descending colon, but in the transverse and the ascending colon it was most difficult to do so. There were adhesions between the different layers of the intussusception, and the coats of the bowel were much thickened and inflamed, with a large quantity of lymph between the layers. As Mr. Dunn separated the layers the fluid exuded from between the surfaces, and in the process of separation the peritoneal coat was torn. Thus the case did not appear at that time to be a very hopeful one, but when I come to the after-treatment you will hear that the child, notwithstanding the serious condition it was in, did very well indeed.

Now in regard to the other two cases, you will remember I told you that the tumour in one of them was over the ascending colon, and in the other over the ascending and the transverse colon. In both these cases we used the funnel apparatus, running the fluid in slowly and at low pressure, and were able to reduce the intussusception, as we thought completely, in both cases. The fluid was allowed to stop in the intestine for some time, but soon after letting it flow out it was obvious that there was a tumour still present in the right iliac

fossa. The tumour was quite a small one, very much less in size than that previously present. And yet the tumour had not really recurred in these cases, but was present all the time. We inflated again, and after allowing the fluid to flow out, no tumour could be felt. In a little time the tumour was again felt.

In both cases abdominal section was then performed, and in each case it was found that at the commencement of the intussusception — supposing this (on blackboard) to represent the ileum, this the sigmoid, and this the vermiform appendix—the adhesions in the neighbourhood were so firm as not to allow of their separation by means of inflation. I would impress upon you that it is this initial part of an intussusception which is so difficult to reduce by means of inflation.

I will now go on to discuss the treatment generally. An early recognition of the condition is absolutely essential. If you only recognise the disease early enough, you may be able to do something for it, and thereby help to reduce the awful mortality which has been associated with this disease. Our choice lies between inflation and immediate abdominal section, or first inflation and failing reduction, then opening the abdomen as soon as possible.

Let us consider inflation first. There have been a good number of successes as the result of carrying out this method, and that is a very great point in its favour. You have not then to deal with the serious shock which often ensues after opening the abdomen in children. But you are not likely to do any good by means of inflation if your intussusception has lasted longer than forty-eight hours. By that time adhesions will have formed and become fairly firm, and so the difficulty of inflating satisfactorily will be very great.

What should you inflate with? I think it is better to inflate with fluid than air, because you get a more equable pressure, and with the cistern funnel apparatus you can run your fluid slowly in, under as low a pressure as possible, and so gradually distend the abdomen. Mr. Dunn advises the use of boiled milk and water, one reason being that you see the milk more easily when it commences to run out, and another being that if the child absorbs the fluid it has got something which is useful to it. Boiled milk and water is a very good fluid to use.

The amount you should run in varies very much in different children. You may use about one pint if the child is five months old, and over a pint if it is a child over six months.

With regard to the funnel, it ought not to be held more than two to two-and-a-half feet above the level of the rectum. If it is held much higher the pressure might rupture the gut. Usually you should allow the fluid to remain in for ten minutes, because by so doing you are keeping up the pressure, and if the adhesions are not too firm it may overcome them in that space of time.

In performing the inflation you should keep your hand on the abdomen so as to see that the bowel is only gradually distended. If you feel a sudden distension of the abdomen it would probably mean that you had ruptured the gut, and you would therefore proceed at once to open the abdomen.

As to the length of the intussusception, it does not make much difference. Intussusceptions which have protruded from the anus have been reduced in several cases by means of inflation only.

The disadvantages of the method are: (1) That you cannot see what you are doing, and (2) that you may over-distend the intestines and rupture them. But when you consider the very bad results that have followed abdominal section, even though there is a chance of rupturing the intestines, it is better on the whole to try inflation first. (3) That it is very difficult to tell whether the intussusception is completely reduced. In the two last of our cases, the child of five months and the child of six months, we thought we had reduced the intussusception completely, but we had not. The symptoms recurred again, and, as I told you, the probability was that the intussusception had not been reduced. There is no doubt that some intussusceptions after inflation do recur after a long interval. For instance, they may recur twenty-four hours after being reduced, even though the bowels have been opened in the interval. That recurrence is more likely to ensue with inflation than with abdominal section. (4) That if the symptoms do continue after you have inflated you have lost a good deal of valuable time.

Now let us consider the question of abdominal section. Do not think, though abdominal section was performed in all these three cases, that I am advising you to do it first in all cases of intussusception. It would be the last thing that I should advise you to do. I should say that you ought to try inflation first, and perhaps a second, or even a third time. But in considering abdominal section nowadays, you are justified in taking a more hopeful view than you would have been some few years ago, because the methods of surgical procedure and

the rapidity with which they can be carried into effect have much improved within the last few years. In these three cases, although, or because, perhaps I should say, the abdomen was opened, the children recovered. Of course, these are very happy results, and we cannot expect to get anything like that percentage in the aggregate. But still, it shows you that abdominal section, as such, is not so fatal a procedure as it was originally thought to be in children. I should certainly, then, recommend that in the majority of cases you should first try inflation, and if it be unsuccessful at once proceed to abdominal section.

Now you must always bear in mind that the great danger of abdominal section is *shock*, and therefore you must do everything you can to prevent, or minimise this. These three children were all cold and collapsed, and both before, during, and after the operation we had their legs and arms wrapped in cotton-wool and hot bottles put round them.

The next essential point is rapidity in the operation. I do not remember how long it was in each of these three cases, but in the two cases Mr. Steward operated on, the time for each was about twenty minutes, and in Mr. Dunn's case, although somewhat longer, on account of the extreme difficulty of the case, it was still quite short. We therefore owe many thanks to them for the successful results. In two of the cases the peritoneum was unavoidably torn but no bad results ensued.

With regard to the after-treatment, you must remember that a child, five, or six, or even eleven months old, has very little resisting power. Hence it is rather extraordinary that children so young should be able to stand the shock of an abdominal section, and yet you see they can. I think it is wise to feed the child as soon as he recovers from the anæsthetic; not to cram food down his throat, but to give him some. To the child of eleven months old, we gave fifteen minims of milk and barley-water, and increased the quantity by five minims an hour, every hour, until the next morning; also an enema of one drachm of brandy and four ounces of milk immediately after the operation. Next morning we put the child on three ounces of Horlick's milk every three hours. In addition to the above, half a minim of opium every six hours was given for thirty-six hours after the operation.

To the child of five months old half an ounce of milk with half an ounce of barley-water and five minims of brandy were given at 2.30 a.m., an hour after the operation. This was repeated at 4.30 a.m. At 6.30 and 8.30 the child had two and a half ounces of milk and barley-water and five minims of brandy. After that it was given one ounce of Horlick's milk every hour. Vomiting occurred once after the operation, but otherwise the case did perfectly, despite the fact that the child was much collapsed after operation, and was made, and kept, warm with much difficulty. The treatment in the other case was conducted on similar lines.

Thus, what I want to impress upon you as to the treatment of these cases is, that it is most important to keep the patient warm; that it is most important to prevent shock in every way you can; that if you cannot reduce the intussusception after a well-tried inflation you should proceed to an abdominal section at once, and having done so you may regard the prognosis as better than it used to be in days gone by.

There is one other point to consider. What are the varieties of intussusception met with? In each of these three cases it was the ileo-cæcal form, and that is far the commonest. In this form you have the apex of the intussusception formed by the ileo-cæcal valve. You know how the condition is produced. One part of the intestine passes down into and is ensheathed by another part, and so the intussusception consists of three layers; the outer layer of the colon which is called the ensheathing layer, the middle layer which is called the receiving layer, and the inner layer which is called the entering layer. That (indicated) is the neck of the intussusception, and that is where the sloughing occurs. That (indicated) is the apex of the intussusception formed by the ileo-cæcal valve, and it was this part which we felt on examination per rectum. Now, as the tumour increases the apex remains the same; the tumour increases in size by an increase in the amount of the colon which is turned in.

There are other forms. There is one which is called the ileo-colic form. The other varieties are the enteric, colic and rectal forms.

In the ileo-colic form the ileum is prolapsed into the colon. It is a rare form. The prolapse does not go on to more than a certain extent. After a time no more of the ileum becomes so, and the increase in the length of the tumour takes place at the expense of the external layer of the colon.

The enteric, colic and rectal forms of intussusception occur in the course of the small intestine, in the course of the colon, and in the rectum respectively.

For the last few minutes I should like to discuss the pathology of the process. We see

intussusceptions in the post-mortem room, which occur either during or after death. We know that after that period irregular peristalis occurs, and that is how such intussusceptions arise. In children, intestinal disturbance is very readily set up; the intestinal muscle is readily excited, and this probably accounts for the frequency of intussusception in them. It may be that some undigested food, or a polypus, or some foreign body, such as a plum-stone, sets up irregular peristaltic contraction, and an intussusception is produced. Then the invagination increasing, the mesentery is drawn in with the bowel, till ultimately this intussuscepted portion becomes pulled up against the mucous membrane of the ensheathing layer, and a complete obstruction results. In consequence also of the pull the mesentery exerts, there is a slit, instead of a round opening, at the apex. The intussuscepted portion becomes bent or curved in outline and the coats œdematous from the vascular obstruction, all these factors aiding in the completion of the obstruction.

I see that my time is up, but I think I have dealt with the most important points I wished to bring before you to-day.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Taylor.

Mary	39.	Mitral stenosis. ? Fibroid lung.
	40.	Typhoid fever.
	41.	Mitral regurgitation.
	43.	Aortic and mitral stenosis and regurgitation.
	45.	Tubercular kidney. Excision.
	48.	Exophthalmic goître.
	59.	Chlorosis.
	50.	Gastric ulcer.
Philip	21.	Tubercular laryngitis and phthisis.
	23.	Right hemiplegia and aphasia.
	24.	Diabetes mellitus.
	25.	Aortic stenosis and regurgitation. Mitral regurgitation.
	27.	? Typhoid fever.
	29.	Mitral stenosis and regurgitation.
	30.	? Cerebral abscess.
	32.	Old right pleurisy. Left pleurisy. Peripheral neuritis.
	34.	Ascites.
	35.	Acute rheumatism. 2nd attack.
Philip	36.	Appendicular abscess. Incision.
	37.	Morbus cordis.
	38.	Chorea.
	40.	Aortic regurgitation.

Cases under Dr. Hale White.

Mary	13.	Cerebral tumour.
	14.	Acute osteo-arthritis.
	15.	Mitral regurgitation. Enlarged liver.
	16.	Cerebral tumour. Operation.
	17.	Typhoid arthritis.
	18.	Mitral stenosis and regurgitation. Right pleuritic effusion. Œdema of legs.
	19.	Enlarged spleen. ? Cause. Operation.
	20.	Typhoid.
	21.	Right pleuritic effusion. Phthisis.
	22.	Lateral sclerosis.
	23.	Chlorosis.
	24.	Diabetes mellitus.
Cot	53.	Posterior basal meningitis. Recovery.
Philip	1.	Acute nephritis.
	2.	Appendicitis. Operation.
	3.	Diabetes mellitus.
	4.	Phthisis. Pulmonary osteo-arthropathy.
	5.	Chronic tubal nephritis.
	6.	Chronic interstitial nephritis.
	7.	Typhoid fever.
	8.	Typhoid fever.
	9.	Carcinoma of liver.
	13.	Mitral regurgitation. Enlarged liver. Albuminuria.
	14.	Phthisis. Fibroid lung.
	17.	Eczema.
	18.	? Pyloric growth.
	19.	Typhoid fever.
	20.	Acute rheumatism. Mitral regurgitation.

Cases under Dr. Bryant.

Mary	25.	Phthisis.
	26.	Oxalic acid poisoning.
	27.	Enterica.
	28.	Mitral stenosis and regurgitation.
	30.	Jaundice.
	31.	Chlorosis.
	32.	Pleurisy with effusion.
	33.	? Dilated stomach.
	34.	Hemiplegia.
	35.	Broncho-pneumonia.
	36.	Empyema.
	37.	Acute rheumatism. Pericarditis and endocarditis.
Stephen	21.	Enterica.
	22.	Angina and mitral regurgitation.
	23.	Acute rheumatism. Endocarditis.
	24.	Pleuritic effusion.
	25.	Enterica.
	26.	Senile heart.
	27.	Hemiplegia.
	28.	Malarial spleen.

Stephen	29.	Mitral regurgitation.
	30.	Mixed nephritis.
	31.	Phthisis and peripheral neuritis.
	33.	Paraplegia.
	34.	Carcinoma of stomach.
	35.	Acute rheumatism. Endocarditis.
	36.	Exophthalmic goître.
	37.	Œdema of legs. ? Cause.
	38.	Paraplegia and tremors.
	39.	Tricuspid and mitral disease.
	40.	Multiple melanotic sarcomata.
Cot.		Mitral stenosis and regurgitation.

In the Surgical Wards.

Cases under Mr. Howse.

Job	11.	Varicose veins. Excision.
	25.	Varicocele. Radical operation.
Lydia	4.	Fibrous epulis.
	6.	Talipes equinus.
	8.	Lupus of face.

Cases under Mr. Lucas.

Astley Cooper	12.	Gunshot wound of hand.
	16.	Fractured patella.
	21.	Fractured tibia.
	26.	Ruptured spleen. Excision. Death.
Lazarus	5.	Urinary abscess.
	6.	Fistula in ano.
	7.	Gonorrhœal arthritis of knee.
	15.	Stricture of urethra.
	20.	Syphilitic arthritis of ankle.
Martha	2.	Carcinoma of breast.
	17.	Syphilitic destruction of nose, and periostitis of tibia.

Cases under Mr. Golding-Bird.

Cornelius	5.	Compound subastragaloid dislocation.
	9.	Concussion.
	20.	Pott's fracture.
Charity	4.	Fractured neck of femur.
	5.	Scalp wound.
	11.	Tuberculous ulceration of loin and popliteal abscess.
Luke	8.	Cellulitis of neck. ? Lateral sinus thrombosis.
	13.	? Gumma. ? Fibroma of breast and urinary fistula.

Cases under Mr. Jacobson.

Dorcas	6.	Ventral hernia.
	10.	Gummatous ostitis of tarsus.
	12.	Carcinoma of breasts and abdominal tumour.
Naaman	1.	Lumbar pain and swelling. ? Calculus. ? Renal growth.
	5.	Talipes equino-varus.
	20.	Hare-lip.

Cases under Mr. Symonds.

Lydia	20.	Empyema of antrum.
	21.	Recurrent sarcoma of tonsil.
Job	13.	Femoral hernia. Radical operation.
	17.	Nasal obstruction.
Patience	15.	Thecal abscess and palmar suppuration.

Case under Mr. Lane.

Martha	12.	Sarcoma of thigh. Amputation.

Cases under Mr. Dunn.

Luke	4.	Recurrent appendicitis.
Charity	21.	Recurrent appendicitis.
Patience	1.	Necrosis of jaw. Alveolar abscess.

Cases under Mr. Fripp.

Naaman	20.	Closure of jaws. Old cancrum oris.
Dorcas	19.	Prepatellar bursal enlargement.
	21.	Pain in knee. ? Cause.

Post Pharyngeal Abscess.

Three cases have recently come under my notice and are worth recording.

Case A.—An anæmic child, æt. 2, brought up at midday from a house from which a child with diphtheria had been removed four days previously. Temperature 99°, face pallid, lips blue, urgent obstruction and dyspnœa, with great sucking in. Fauces—right tonsil bulging forward, no membrane, some injection. Laryngeal diphtheria was diagnosed and antitoxin given. About three hours later the ambulance arrived for the child whose dyspnœa had abated though it was still alarming. Before removal the improvement caused considerable qualms of conscience but the history was deemed conclusive. The child went to the Park Hospital where the superintendent courteously intimated that there was "a soft fluctuating swelling on the post pharyngeal wall running round and bulging the right tonsil inwards." The swelling was not visible with a spatula but was appreciable with a finger. The swelling was a post pharyngeal abscess and was opened on its return to Guy's, two days later, through the mouth. Recovery.

Case B.—A girl of three attended the surgery for four weeks with a history of obstruction to breathing. On the day of admission for urgent dyspnœa, right tonsil was projecting and was reddened; the temperature was 99·4°; no membrane was visible. A cultivation was taken, and proved negative. The child was admitted and given antitoxin. *Its breathing was by twos and threes.* The dyspnœa grew alarming, and tracheotomy was decided on. It began after the patient had stopped breathing, but the patient resumed breathing and the operation (a troublesome one) was finished under A.C.E. Two days later the pharynx was explored and a post pharyngeal abscess opened behind the sternomastoid. Recovery.

Case C.—Child æt. 10 months. Family history of tubercle. Temperature 98·4°. From the report—"Five weeks ago the child was brought up to the front surgery, and when the spatula was withdrawn after looking at its throat, a large amount of discharge came away. The child seemed drowsy, and was treated for bronchitis. The child was brought up again to the front surgery and was admitted at 1 p.m. Diphtheria was diagnosed, and a special nurse was put on and antitoxin administered. Later on, as the child had great difficulty in breathing, *stopping and then going on again*, an immediate tracheotomy was deemed advisable. Mr. Symonds, in the absence of the other surgeons, kindly consented to see the case, and thought the breathing rather remarkable to be due to diphtheria, and on putting his finger in the child's throat he confirmed his diagnosis on sight of retropharyngeal abscess." It was opened behind the sternomastoid under chloroform three hours later, the dyspnœa continuing, and the breathing stopped under the anæsthetic. Recovery.

It was never impressed on me, nor apparently, judging from similar cases, is it grasped that every case of laryngeal diphtheria requires a digital examination to avoid the mistake made above.

In all the cases there were several points in common that should be noted.

The previous history of "throat trouble," the length of time the obstruction had lasted, and the special points that though the dyspnœa was urgent still the child did not go black in the face, and though it stopped breathing it spontaneously resumed it, which never occurs in laryngeal diphtheria. Caiger remarks that, "laryngeal diphtheria is most common in young children, and that croup is more often primary than secondary," and "no trustworthy indication can be derived from the character of the respiration, the quality of the cough or laryngeal sound"; thus far these points being points on which laryngeal diphtheria in the cases was rightly considered.

Mr. Symonds pointed out in the last case that the character of the breathing was that of pharyngeal obstruction and not laryngeal, and before examination pronounced it probably not diphtheria, basing his opinion on the character of breathing and the fact that the urgent dyspnœa had not caused cyanosis and was not rapidly progressing to asphyxia.

Mr. Symonds recommended that the abscess should be opened behind the sternomastoid.

There was no evidence of caries in any case.

Pass List.

Royal College of Surgeons of England, November, 1900.

PRIMARY FELLOWSHIP EXAMINATION.

A. R. Brailey, F. M. M. Ommanney, E. A. Peters.

Multiple Lesions.

The following case may be of interest to your readers on account of the number of apparently separate diseases:—

We were summoned in the evening to see S. A. L., female, unmarried, aged 40, residing three and a half miles in country. On arriving at the house she was found quite alone, extremely ill, very pallid and emaciated, rolling about on the floor doubled up with acute abdominal pain. She had a feeble, thready pulse; temperature normal. She was not able to give a very clear account of herself, and between the paroxysms of pain was trying to vomit. As far as could be gathered, she attributed her condition to the fact of eating some fish the previous night, as the pain came on directly after the meal. During the night she had some diarrhœa and vomiting of frothy green-coloured fluid; next day no cessation of the pain and vomiting. On examining the vomit there was no fæcal odour.

Previous history.—The last two years' menstruation had been irregular, and she had suffered with a foul blood-stained discharge from vagina. She had suffered much pain, and had noticed she had been getting gradually very thin and weak, and had frequently vomited.

On examining the abdomen, a tumour over the left femoral ring was found, about the size of a hen's egg; very tense. No impulse on coughing. The tumour turned upwards over Poupart's ligament. There was no pain on manipulation, and she stated she had noticed the swelling "some time," and it had caused her no trouble. A marked symptom in her condition was that she suffered from delusions of persecution, thinking her neighbours were spying into the house and listening to and laughing at her conversation and trouble.

A hypodermic injection of morphia was given, and with great difficulty she was eventually persuaded to come into the Retford Hospital, where she was admitted under Mr. Thorne.

On admission, the abdomen was tense, with a generally dull note over the lower part, becoming tympanitic over stomach. She was still suffering from pain and vomiting, which was silghtly relieved by the morphia. On examining per vagina, cervix was normal; bimanual examination, uterus was very hard and decidedly enlarged.

It was decided, after much opposition from the patient (who at last consented), to operate for strangulated femoral hernia. Though the symptoms were not characteristic, it proved to be strangulated femoral hernia, and the gut was without difficulty returned, the sac dissected away and ligatured, and the ring sutured. After the operation the patient ceased to vomit, but gradually sank and died about twenty-four hours after the operation, although she was able to take liquid nourishment freely.

At the post-mortem examination of abdomen the following was found. The intestine generally healthy, with no peritonitis. The portion of small intestine

which had been relieved by the operation looked healthy, though congested.

On opening the abdomen a large cystic tumour appeared in the middle line, tense and regular in outline; on tracing it downwards it was found to be attached by a thin pedicle to the left broad ligament, the left ovary was stretched by the tumour, but otherwise both ovaries appeared healthy. A ligature was placed round pedicle and the tumour removed intact without difficulty; there were no adhesions. On cutting into the cyst about two pints of clear straw-coloured fluid escaped; the sac wall was white in colour, thin and regular in all its extent. The uterus was next removed; it was about three times its normal size; very hard and firm. On section, the body was found to be infiltrated by new growth, the uterine canal was full of adherent matter, composed of broken down mucous membrane and blood. There were no secondary growths, and no adhesions of uterus to other viscera. The external os uteri healthy, smooth and thickened.

The abdominal viscera anæmic, otherwise healthy.

P. E. BEARBLOCK.
Retford, November, 1900. J. M. THORNE.

Religio Medici.

The Bishop of Rochester, Chaplain and Governor of the Hospital, gave the first of a series of winter lectures to the Students in the Court Room, on Thursday, November 15th. He took as his subject the advantages and dangers of specialism. Having pointed out that in every department of knowledge the tendency was to specialization, he said that this tendency was in itself a good and useful one. It encouraged in the student the qualities of modesty (for he realised the vast range of possible knowledge), of industry (for he had to cover so much ground), and of prudence (because he was made to feel his own limitations). At the same time, specializing had its dangers, and these might be expressed in the words—(i.) narrow-mindedness, and (ii.) narrow-heartedness. It was easy to become so absorbed in our own department of study and work as to forget what lay outside of it.

Yet there are many things which cannot be neglected with impunity, and religion is one of them. "I grant you," he said, "that the religious aspect of things can be easily put out of sight. Religion deals with the invisible, and therefore it is easily forgotten. Is there not a distinct tendency in some minds to shelve religious questions—a tendency re-enforced by the hurry of life on the one hand, and by all that is morally soft in us on the other? My word to you is, *Don't specialize against God.* If you ask me Why? I should answer, For this reason, if for no other, that, granted the necessity of a religion, Christianity at least holds the field. Or, to put the same thing a little differently, Don't specialize against Christ, because Jesus Christ is at least the acknowledged Head of moral humanity."

The Bishop went on to remark that probably it was true that the thoughts in most men's minds about Christ and Christianity contained something of caricature. It was therefore necessary to get right back to the heart of the matter. Jesus Christ summed up in Himself the truth about God. He claimed to be the guide of human living—the Way, the Truth, and the Life. If this claim was true, it was a tremendous claim. To ignore it was to specialize against ourselves, and against our own consciences.

The lecturer concluded by advising his audience to read other books besides those connected with their special studies—a little fiction and poetry, and, above all, the Scriptures; and, as a help to the study of the latter, he recommended a little book by Canon Gore, "The Creed of the Christian," which he described as a short, compact and really modern presentation of Christianity.

Notices.

MEDICAL SERVICE WITH HER MAJESTY'S FORCES IN SOUTH AFRICA.

Particulars of the conditions under which Civil Surgeons will be appointed to serve in South Africa may be seen upon application in the Dean's office. There are several vacancies at present to be filled.

L. E. SHAW, Dean.
Guy's Hospital, December 5th, 1900.

Applications are invited for the post of Demonstrator of Practical Dentistry, to attend on Wednesday afternoons, and should be addressed to the Treasurer, Superintendent's Office, on or before Wednesday, December 19th, 1900. L. E. SHAW, Dean.
Guy's Hospital, December 5th, 1900.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Bradshaw Lecture.

Notice is hereby given that the Bradshaw Lecture will be delivered in the Theatre of the College by John Langton, Esq., F.R.C.S., on Wednesday, the 12th of December next, at five o'clock p.m. precisely.

The subject of the lecture will be "The Association of Inguinal Hernia with the descent of the Testis."

Fellows and Members of the College are invited to attend.

Students and others who are not Fellows or Members of the College, will be admitted on presentation of their private visiting card.

EDWARD TRIMMER, Secretary,
12th November, 1900.

INDIAN MEDICAL SERVICE.

An Examination for Commissions in Her Majesty's Indian Medical Service will be held in London in February, 1901.

Copies of Regulations for the Examination, with information regarding the pay and Retiring Allowances, &c., of Indian Medical Officers, may be obtained on application to the Under Secretary of State for India, India Office, London, S.W.

The exact date of the Examination and the number of Commissions to be competed for will be announced hereafter.

F. WHITMORE SMITH,
India Office, Assistant Military Secretary.
22nd October, 1900.

THE SANITARY INSTITUTE.

A sessional meeting of the Institute will be held at the Parkes Museum, on Wednesday, December 12th, at 8 p.m., when a discussion will be opened on "Some Practical Aspects of the Plague at Sydney" (with illustrations), by Frank Tidswell, M.B., Ch.M., D.P.H., Principal Assistant Medical Officer of the Government of New South Wales. Tickets for the admission of visitors may be obtained from the Hospital Librarian.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

South African Memorial Fund.

DEAR SIR,—I inclose my subscription to the South African Memorial Fund. I hope that whatever other form this memorial takes, it will not be a stained-glass window in the Club.—I am, yours faithfully,

WALTER C. C. PAKES.
Guy's Hospital, S.E.,
5th December, 1900.

DEAR SIR,—I think the best suggestion yet made for the South African Memorial is that of an artistic bronze tablet in some such conspicuous place as the wall of the front entrance or colonnade. I enclose a guinea, with sincere sympathy with the object of the fund.—Yours truly,

R. J. PYE-SMITH,
350, Glossop Road, Sheffield,
26th November, 1900.

DEAR SIR,—I have pleasure in enclosing a subscription to the South African Memorial Fund.

A monument in the park seems to me the best way of perpetuating the memory of some of the dearest men we have had amongst us, who have fallen in the war.—Yours sincerely,

PERCY F. HENRY.
79, King William Street, E.C.
November 26th, 1900.

DEAR SIR,—In the last issue of your journal you say that the funds for the South African Memorial are not coming in as fast as was expected. May I venture to suggest a reason for this delay?

At the present moment we are asked to subscribe to a fund. After the necessary amount has been subscribed, the money is to be expended in the manner which the Gazette Committee shall think fit. You, Mr. Editor, and your committee are most excellently fitted for collecting and acknowledging the subscriptions, but I fail to see your qualification for administering the Memorial Fund.

I should suggest that a general meeting of the subscribers and sympathisers be called, that the president of the Clubs' Union, Dr. Pye-Smith, be asked to take the chair, that the matter be discussed at that meeting, and that a committee be elected at that meeting to administer the fund in accordance with the wishes of the meeting.

If this were done I feel sure that subscriptions would not be lacking to enable us to raise a fitting memorial to those who have lost their lives in South Africa.

I enclose a small subscription and my card, and remain, yours truly,

ONE OF THE OLD DISGUYSED.
London, December 3rd, 1900.

Out-Patients' Tea Fund.

DEAR SIR,—May I ask you to insert the following slight contradiction:—

In the last number but one of the GAZETTE you announced that the proceeds of the Smoking Concert would be given to the Out-Patients' Tea Fund. This is not the case at all, as the Tea Fund is not to receive anything from that source. The knowledge that your announcement has deterred many from subscribing to the tea, is my excuse for troubling you in the matter,—I am, etc.,

E. W. GOBLE, Hon. Sec.

Papers by Guy's Men.

On the Methods of making Antitoxic and Preventive Fluids, with special reference to those of Plague. By C. Balfour Stewart, M.A., M.B. Illustrated.—*British Medical Journal*, 27th October.

A Note on the Organization and Conduct of Plague Laboratories. By Walter C. C. Pakes, D.P.H. Camb.—*Ibid.*

With Dr. Hale White in the Wards of Guy's Hospital.—*Clinical Journal*, 7th November.

A Clinical Lecture on Empyemæ following Lobar Pneumonia. By W. Hale White, M.D., F.R.C.P. Lond.—*Lancet*, 10th November.

Two Cases of Acute Hæmorrhagic Pancreatitis. By J. H. Bryant, M.D., M.R.C.P. Lond.—*Ibid.*

An Address on the Treatment of Sprains and of some Fractures. Delivered before the Hampstead Medical Society. By A. H. Tubby, M.S. Lond., F.R.C.S. Eng.—*Lancet*, 17th November,

Passim.

Just when we had assumed a mental attitude of sublime content, and were prepared to view the whole world from some lofty standpoint through glasses rosy almost to crimson, we were brought back with a jerk to the land of the present—the dirty, rainy, muddy present—by a letter from "One of the Old Disguysed." It was almost like receiving a splash of mud on an immaculate shirt front; sudden, appalling, paralysing, and the more so that it was unanswerable. To be told that we are excellent as collectors and acknowledgers, but that in anything beyond we must not presume to claim the prerogatives and powers of our superiors. To have it denied calmly and deliberately that the Art Sub-committee of this Gazette is a fit and proper body for the duty of selecting a suitable and sufficient memorial; to have it suggested that the only persons who are properly qualified to deal with such a matter are the subscribers to the fund—all of these fill us with feelings that are incapable of description. For it was to this tune that we imagined we had been piping all along!

It was early realized that a vague "something" should be done to commemorate in this hospital our share in the Boer war. It was felt also that somebody—again a vague entity—should take the first step in this something, but although we hinted, and hinted again, in these columns, no one was ready to take the initiative. Accordingly the committee of this Gazette took upon itself to give life to the scheme, and to this end the columns of the Gazette were employed. But we have, all through the piece, refrained consistently from giving any definite form to the memorial. We have invited the views of correspondents and suggested a meeting of subscribers. We have in no wise submitted that our *motif* was any but to serve as a means of communication between the diverse contributors, and we have always restrained the natural impulse to put forward our own views, in consideration of the part which we conceived we were playing. Hence our surprise at "One of the old Disguysed's" letter. Since, however, he enunciates a definite project, and suggests a general meeting with Dr. Pye-Smith in the chair—and no man could be more fitted for the post—we can only say that nothing would please us better, and that we believe nothing could more materially advance the cause of the memorial.

An occasional Nursing Correspondent, whose information is usually semi-official at the very least, sends us a communication which will doubtless be of interest to our readers on the nursing side. The arrangements for Christmas will be somewhat modified from those which have held good in previous years, but it is not considered that the changes will militate against the enjoyment of everyone at this season. The decorations, for one thing, will be somewhat simpler and less extravagant because less expensive; also at the ward concerts, the little side-shows that please the palate and the eye, the kaleidoscopic candle effects, and the insidious little collections of sweetmeats will all be on a much smaller scale. We hear that this year the custom of collecting from individuals for Christmas presents is to be entirely given up, as it is really found to be a very heavy tax on many who could ill afford it. This last remark, however, does not apply to the usual collections which are made among the men for the purpose of rendering Christmas at Guy's, for the patients at any rate, a red-letter day in the drab annals of their lives. These will hold as usual, and will be met by the same hearty response as of old.

The new laundry has washed its first apron. For some little time the machines have been put to trial-runs, and the thousand and one little defects that only become manifest on ocular demonstration have been detected and remedied; and now a portion of the laundry staff is busy at work on its task of becoming familiar with the strange and wonderful machinery of a twentieth century power-laundry. Electricity, generated by as fine an installation as could possibly be imagined, is the motive power for the washers, ironers, hydro-extractors, and the other mechanical contrivances for reducing hand labour to a minimum. A visit to the boiler-house, where the four huge, mechanically-stoked boilers generate steam, at present for the engines, and in time for heating purposes, reminds one of a descent into the bowels of some huge Atlantic liner, while a peep into the engine-room, with the high-speed engines, the whirring dynamos, and the dozen odd motors all humming in busy earnest, makes the memory hark back in wonder to the grand old bookseller and his magnificent scheme. It is still Guy's Hospital and it is worthy of his memory. The hospital engineer is to be most heartily congratulated on the splendid results that he has achieved.

A country contributor to the funds of this hospital, during a short visit to town, spent an odd half hour in looking through a portion of the hospital, and was evidently very deeply impressed. Quite spontaneously he submitted an account of his visit to us, which we have refrained from printing lest we should incur the reproach that we had become self-laudatory. But one or two little points in his article are so entirely antagonistic to the belief,—the word opinion implies the exercise of a certain amount of mental power—of the gutter-press, that we hope we shall be forgiven if we publish them. In visiting one of the medical wards our correspondent was struck with the general sense of comfort that pervaded everything. "Some patients were sitting at tables writing to friends, others lounging in easy chairs, some were in wheeled chairs, and moving about the ward, others reading newspapers or books from the very excellent library provided." He only spoke to one patient, but found the man deeply grateful for all that had been done. Grateful to the physician, and to the house-physician, and above all grateful to the ward clerk who gave up his Sunday in order that the patient might be dressed. The half-hour's visit was a revelation to our correspondent, and it was plain, he says, "that the various departments of science in Guy's were all united in one common cause, and for the common good of those around them."

An announcement is made from the India Office that there will be an examination of Candidates for Commissions in Her Majesty's Indian Medical Service, and that the examination will be held in London on some date, not yet fixed, in February, 1901. Copies of the regulations applicable to this Service may be obtained from the Librarian, Guy's Hospital.

For the second time this year we have to complain of the ungentlemanly conduct of certain men during lecture time. It is at all times disconcerting to a lecturer to have to address an unsympathetic audience, but when that audience, or rather a small portion of it, not only refrains from any semblance of attention but openly indulges in conversation, in audible tones, it is both insulting to the lecturer and intolerable to the majority who are interested. We do not intend here to enter into any discussion on the value of the lectures given at Guy's Hospital; in the case of the lectures to which we are referring at the present moment, the large attendance and the obvious interest with which this course is received makes the action of the few who are incapable of realizing the value of the subject still more reprehensible. In justice to the men who are willing and eager to listen, we hope that the rowdy element in the New Theatre will restrain its feelings for a more suitable place or in default abstain from attendance entirely. It may be reasonably pointed out that the manners and customs of the Hooligans sit awkwardly on the shoulders of the registered student.

Another annoyance to which the studious man is subject is due in part, if not entirely, to mere thoughtlessness and the exuberance of happy boyhood. The old Chemical Theatre lies very close to the Library, and has an absurd approach through a narrow passage and up a flight of wooden steps. On the assembly of a class in, and its dismissal from this theatre, the noise caused by many boots on bare boards is always disconcerting to those who are trying to read. But when in addition horseplay and wrestling entertainments are added, the din becomes simply deafening, and work is rendered for the time being impossible. If the men who are responsible for these little variety shows would remember that in future years the positions will be reversed, and remember also that tradition is all-powerful at Guy's, they may by sober behaviour now build up a precedent which shall ensure them quiet for reading in the years to come, when they will need it. We hope this hint will be sufficient.

Attention is called to the notices issued by the Medical School, in which applications are invited for the post of Demonstrator of Practical Dentistry, and in which also men are reminded that the War Office is still prepared to accept the services of civilian medical officers in South Africa. Details of these latter appointments may be obtained from the Medical Office.

In these days of universal education, it is not absolutely unknown to find a patient talking to the ward-clerk of cocci, and of bacilli, and expressing confidence or the reverse in the results of Widal's reaction. It is therefore quite refreshing to come across a "Hospital Doctor" whose ignorance on these matters is as profound as his disregard for the ordinary rules of orthography. Two choice productions in the Bacteriological direction have lately seen the light, and in each the good faith of the perpetrator is above dispute. In one the ward-

clerk, in submitting a "specimen for bacteriological examination" gravely replies to the question "what organism suspected?" with the words "Tubercle Bacillus or the Gonnococcus Bacillus." In the other case the clerk introduces a spirit of levity by asking for the "T.B. or the Gohonnococcus." To which we reply "Go hon yourself."

Following the lead of many less celebrated journals, our much esteemed contemporary, the *Lancet*, has at last tripped up over the typhoid question. In the column of "Annotations" in the issue of November 24th, we found the following reference to the illness of the Czar of Russia. The quotation here given follows on a dissertation on the extreme mildness of the Imperial attack. "Indeed, judging from the temperature and pulse rate, a physician would hesitate to make such a diagnosis (*i.e.*, typhoid fever). The evening temperature ranges from about 101° F. to a little above 102° F., whilst in the morning only a little above 100° F. has usually been registered: the pulse has varied between 70 and 80 per minute. Such a range of temperature and rate of pulse do not negative a diagnosis of enteric fever, although such conditions are rare, but in this instance they would seem to point to a light attack, etc." Reference to "Practice of Medicine," by Frederick Taylor, fifth edition (1898), page 40, line 10, *et seq.*, shows the following remarks on the pulse in enteric fever:—"Though in some cases very rapid, it is generally, in relation to the temperature, much slower than in typhus and many other febrile conditions; it may never exceed 100, and a pulse of 80 may co-exist with a temperature of 102° or 103°." Comment is needless.

A correspondent has called our attention to the fact that the smoking-room between the hours of nine and ten a.m. is always full of smoke. We are always delighted to receive items of interest connected with the hospital, and we beg to thank him for his entertaining communication. It seems to us to be only proper that the smoking-room should be full of smoke; it it quite in keeping with the traditions of these places. It would manifestly be inconvenient and possibly even dangerous if the smoking-room were full of, say, beer. Sometimes when the lavatory drains are out of order it gets half full of water, and on certain debating nights it is full of wheezes. We should be obliged if our correspondent would let us know the next time the smoking-room gets full of anything else.

The Parliamentary Night of the Debating Society was, considering the obvious unfamiliarity of the members with the recognised procedure, an undoubted success. The nearness of Christmas, with the consequent University examinations, robbed the evening of some of the best debaters, but there were plenty present to give the Government several bad quarters of hours. Mr. Pakes made a calm and dignified speaker, and settled all moot points of decorum by a repetition of the magic word "order." The Leader of the House nearly succeeded on one occasion in drawing him into an argument, but he recovered in time and Mr. Brydone collapsed. Possibly the most humorous incident of the evening was when the President of the Local Government Board (Mr. Wales) met the Opposition in their attempt to reduce his grant by one pound "as a protest," etc. Mr. Wales, in his best style, admitted that he would prefer the full ten thousand pounds, but he would not quibble about a mere pound, and rather than appear unpleasant and mean, he would accept the nine thousand nine hundred and ninety-nine. The experiment should certainly be tried again with Saturday night's Opposition on the Government benches.

By the death of Mr. John Lawson Johnston a very interesting personality has passed away. Mr. Johnston has the distinction of having added a new word to the English language, for the patented meat extract by which he made a large fortune, has lent its name now as a generic term for all meat-extracts. It may not be generally known that Mr. Johnston was appointed by France as her Commissioner in Canada when the question of feeding troops, raised by the Franco-Prussian War, was under debate. For his services on this occasion he received the Fellowship of the French Red Cross Society.

From the Gazette's Special Pathologist.

NOTICES.

T. E. D. H., Reigate.—No tubercle bacilli were found in the specimen. PATHOLOGIST.

Guy's Hospital Dental Society.

A paper read before the Dental Society on November 23rd, 1900, by Mr. A. H. Clogg,

PORCELAIN INLAYS.

Mr. President and Gentlemen,—The subject I should like to bring before you for discussion this evening is the question of Porcelain Inlays as compared with Gold Fillings in conspicuous cavities in the front of the mouth; and I shall try to explain one method of making them.

The first and most important advantage is from an æsthetic point of view. There is undoubtedly no filling material yet known, nor is there ever likely to be one, which looks so natural as a perfectly fitted and correctly coloured inlay.

This fact is well appreciated by most people; especially ladies, who prefer to have cement fillings replaced every year and be temporarily beautiful, rather than have golden teeth and be permanently hideous.

Porcelain is a far more permanent filling material than any cement yet devised, as it is absolutely unaffected by the acids of the mouth, and will stand a considerable amount of force. If anyone doubts this, let him insert an inlay in a tooth out of the mouth and then try to get it out, and he will be astonished at the force required to do so. With ordinary care on the part of the patient, and when inserted in a cavity of reasonable depth, an inlay, at the end of six or seven years, will be in quite as good a condition as when first inserted. So, though it may not be strictly permanent, it is certainly much more than a mere temporary filling.

Again, the low conductivity of the material renders it possible to insert an inlay where gold could not be tolerated.

The comfort of the patient and the time of the operator are certainly worth consideration. The operation of filling with gold inflicts a great nervous strain both on the patient and on the operator, and the teeth are in many cases left with a continued sensitiveness; but inlay work is a method of deliberately, and generally painlessly, forming a cavity, for which, when an impression is taken, the filling can be prepared in the absence of the patient. The insertion, too, is very much easier than gold.

It can be decided with certainty if the filling is going to be perfect, both in colour and shape, before fixation.

To obtain this inlay it is necessary, in the words of Dr. Jenkins, that "the surgeon's skill must be united to the painter's eye for colour and to the sculptor's sense of form, besides having an artisan's dexterity," but though some of us may not possess universal genius, I think that with a certain amount of patience and attention to detail, a perfectly satisfactory result may be obtained.

Inlays may be divided into two classes, according to their shape—the circular and the irregular.

Of circular inlays it is not necessary to say much. They are familiar to all of you under the name of Dall's inlays. The outfit consists of several special burs, and the inlays are ready-made in corresponding sizes. The only difficulty lies in the question of colour, and as the inlays are unpolished it requires a little experience to choose the right shade.

The earliest way of making an inlay of an irregular shape was to grind down a piece of porcelain, either from an artificial tooth or a rod of porcelain to fit the cavity. This method was practised about a thousand years ago and was more or less used down to within the last few years, when, thanks to the perseverance of Dr. Jenkins and others, a material was invented which would fuse at a moderately low temperature and yet possess great power of resistance.

The most useful place for an inlay is in one of the front teeth, where a considerable portion of the labial wall has disappeared. The first consideration is the shaping of the cavity, which differs very markedly from that required for gold.

A considerable portion of unsupported enamel may safely be left in front if not discoloured, as may also the tip of a tooth, which would be condemned at once were gold to be used as the filling material.

The margins of the cavity should be shaped, where possible, in the form of a simple curve, without any receding angles or sharp corners, and the edges should be left perfectly square. This last point is very important and is best done with diamond burs, which leave a perfectly smooth edge. If, as is very rarely the case, the decay has involved only the labial surface of the tooth and left the lingual wall intact, the cavity is now prepared. But in the majority of cases the back wall will be found to have suffered quite as much, if not more, than the front, and the best way then of simplifying the operation is to fill the lingual two-thirds of the cavity with some other material than porcelain.

Where decay has involved the cutting edge of the tooth, this part of the filling should be done with gold, as it is capable of standing a certain amount of strain when brought to a fine edge; but where the cutting edge has been left intact, the best material to use is amalgam, firstly on account of its easier manipulation, secondly because the osteo used in cementing in the amalgam will add somewhat to the strength of the tip, and lastly because less separation is required.

In order to fill with amalgam, the front part of the tooth, *i.e.*, the part which the inlay will finally occupy, should be temporarily filled with gutta-percha, thus forming a three-sided cavity which can be easily filled from the back in the usual way with osteo and amalgam.

If the amalgam is used in the old-fashioned way, *i.e.*, depending for its retention on undercuts, it should be thoroughly washed first with alcohol, and then in water and dried, so as to lessen the risk of staining the tooth substance. When the amalgam has thoroughly set and has been polished, the gutta-percha may be taken out and the cavity is ready for taking the impression.

One final point must be noticed in the shape of the cavity, namely, that it should not be pointed at the

extremities, but slightly rounded, and all the undercuts must be carefully filled with some material, *e.g.*, gutta-percha.

There are two methods of obtaining the mould in which the inlay is to be baked. The first method consists in burnishing the platinum or platinised gold (the latter is somewhat softer to use) into the cavity itself by means of small pieces of amadou or cotton wool; then filling up the mould with a drop of wax, replace it in the cavity and burnish the gold well over the edges and extract both the metal and wax together. Wax is preferable to gutta-percha in this case as it may easily be burned out without altering the shape of the mould, and any surplus can be easily absorbed by a little ball of cotton wool.

The other method is to take an impression of the cavity in wax, and finish the work in the laboratory. Composition has been recommended for this, but it will be found that a small piece of it very quickly looses its pliability and becomes hard, unless used very hot.

First of all slightly smear the cavity with vaseline to ensure easy withdrawal, then take enough warm wax to just more than fill it, and press this into perfect adaptation to the body and edges of the cavity by means of a thin German silver band folded round the tooth. It should then be thoroughly cooled. Two or three such impressions should be taken in order to anticipate any accident to one of them.

This method seems to me preferable to that of burnishing foil into the cavity, for two reasons: firstly, it is much easier and quicker to accomplish, and, secondly, because it can be removed more easily and with less danger of warping.

Mr. Relph, of the National Dental Hospital, has constructed an ingenious instrument for taking the impressions. This instrument consists of a hollow tube, into which he puts the material for taking the impression: encircling this tube is a metal sleeve, which he then slides up, thus forming a cavity into which amalgam is carefully packed. This instrument is made in two shapes, round and oval, for use either in frontal or interstitial cavities.

Then using the finest possible plaster, the impression is cast on the bed-plate which is supplied with the small crown-swager. When the plaster is quite hard, warm the wax and take it out and very carefully dry the model. Take a piece of the metal to be used for the mould (number 60 will do very well for medium-sized cavities) and cut it roughly into shape, leaving a sufficient margin to come well over the edges. If the cavity is deep it may be an advantage to cut two or three V-shaped slits to prevent any crinkling of the edges. Anneal this and gently burnish it into the body of the cavity by means of small pieces of amadou. The swaging process is then finished in the small crown swager, and by useing the water-bag suggested by Mr. J. H. Badcock, perfect contact may be obtained with all parts of the cavity, without in any way injuring the edges. Any holes which may occur in the middle of the foil do not matter at all.

Gently lift up the foil by means of its edges, take it out of the plaster model and invest it on a small platinum tray into a thick paste of powdered asbestos and alcohol, taking care to pack the investment over the free edges of the gold so as to hold it in position. Gently tap the tray with a steel instrument to make sure that the foil settles well down into the investment.

Asbestos is preferable to silex as the investing material on account of its greater binding property after being baked, and alcohol is better than water as it will evaporate more quickly.

It is essential that the "body" should be kept perfectly free from all impurities during the mixing. To ensure this, a clean sheet of blotting paper should be laid on the bench, and the mixing slab and spatula must be quite clean. Then having thoroughly dried the investment, proceed to mix up the porcelain. This consists of certain proportions of felspar, silica, and fine clay. The liquid used is a solution of gum.

There are two or three different varieties of porcelain sold at the depôts; the one used here is Ash's low fusing body, and this gives very satisfactory results. Dr. Jenkin's "enamel body" may be fused in a pure gold mould, and it is stated that in consequence of this it loses its colour after a time in the mouth, but he himself seems perfectly satisfied with it. One advantage of his outfit is that he gives twice as many colours for selection as Ash's outfit contains.

The body should be mixed as dry as possible and painted into the mould with a small camel-hair brush, first of all filling up the ends and around the sides and leaving the middle of the cavity empty. Slowly dry this at some four or five inches above a Bunsen flame, then proceed to bake it until a slight gloss appears on the surface. When cold, more body is added till the cavity is nearly full, dried as before and baked. Shrinkage may be prevented to some extent by putting in small pieces of old porcelain teeth, but very little shrinkage should occur if the first baking is sufficient and if the body is fairly dry. The third and last baking is by far the most important, in that it produces the necessary colour, makes the full contour and perfect edges, and gives the smooth and glossy surface seen in enamel.

If the inlay involves nearly the whole length of the tooth it should be made in two different shades to correspond to the colour of the neck and of the tip of the natural tooth respectively, and these may be best matched by selecting an artificial tooth as nearly as possible identical with the tooth in the mouth and having this tooth constantly at hand during the whole process of baking. The colour of the natural tooth should always be determined when the tooth is wet, as drying tends to bleach it.

Other points which influence the colour are, the time taken for fusing, the temperature to which the furnace is raised (over-heating being liable to bleach it), and the cement used for setting: this last process generally tends to darken the inlay and should be taken into account during the mixing of the porcelain.

The colour is also affected by the number of surfaces which the inlay exposes to the light. An interstitial inlay not involving the cutting edge has only two surfaces to which the light has access, and so naturally looks slightly darker than one which has three surfaces.

To produce perfect edges, the body should be built up flush with the cavity edge, but never allowed to overflow.

A full contour is as necessary with an inlay as with any other form of filling material, and there is, perhaps, a tendency at first to build out too fully, but a little practice will soon overcome this difficulty. It is with reference to this point that the great advantage of filling the lingual two-thirds of the cavity with some other material, as stated above, is seen. If this has been done, the tooth will already be in contact with its neighbour.

To obtain a smooth surface the body should be mixed slightly thinner for the last mixing, and after the cavity is quite full the tray is held in the hand and gently tapped with a steel instrument until the surface becomes smooth all over.

The secret of fusing consists in very gradually and slowly heating up the furnace until the necessary temperature is obtained. This is indicated when a dark shade passes over the surface of the inlay. An electric furnace will fulfil this condition better than the ordinary gas and bellows apparatus.

When cold, remove the foil from the inlay and try it in the cavity, and if perfect make the necessary groves on the back of the inlay with a diamond disc, adjust the rubber dam, and proceed to fix it with cement mixed rather thinner than usual. Of course, the cement should be always smeared over the back of the inlay before it is smeared on to the cavity, otherwise the heat of the mouth tends to harden the cement already put in, and causes an unequal mixture. It is rather difficult to hold a small inlay in the fingers and convey it to the cavity without dropping it, and for this purpose there have been one or two instruments designed called "conveyers," but any ordinary instrument and a drop of wax will answer quite as well.

Press the inlay well home and keep in position for two or three minutes until the cement has begun to harden, then trim off all the superfluous cement, and cover up the inlay with a drop of white wax to prevent saliva having access until the cement is thoroughly hard. This wax is unnoticeable, and can easily be removed with the help of a toothbrush.

The inlay will not attain its correct colour for some twenty-four hours after it has been fixed, owing to the colour of the osteo changing during the crystallisation of setting.

An inlay should never be cut on its glazed surface, as it is impossible to thoroughly polish it again, and consequently it becomes darkened in a few months.

In conclusion, let me say that I think it well worth the time spent for anybody to acquire a knowledge of this work. Both you and your patients will be far more pleased by an accurately fitting inlay than by the most elaborate gold filling. Inlay work is a great stride toward perfection in filling teeth, and, while it will not altogether do away with gold yet, gold will be looked upon as out of place wherever a porcelain inlay can be inserted instead of it.

The Humours of Minos.

Thank God the saving gift of humour is not dead! It lifts a feeble head this time at the present London University, that Radamanthine grave of Colonial aspirations, the Imperial Institute, or rather the back-stairs part thereof.

Observe one question set at the B.S. Pass Examination this week:—

1. "Explain in detail, *without using the word 'callus,* the repair of a simple fracture of a long bone." (The italics are ours).

Conceive the consternation among the candidates, fed on callus from their youth up, familiar with its virtues as an old trusted friend (*pace* the Wirers), as callous ('Eving 'elp us for the pun) of its minute structure as they are of its original significance. They took up their pens and wrote.

They wrote of blood and cartilage,
Of leucocytes and things,
Osteophytes and plasma cells,
And bone-connecting rings,
And why the blood is boiling hot,
And whether Cheynes have wings.

But all to no purpose. Every lambent thought that came into their minds had a hole in the centre of it. Take out the word "callus" and the idea lost its meaning. Of what use was periphrasis? It meant just the same and was less concise. Besides, it wasn't right; the examiners did not want to hear about callus in any disguise. So all hope was abandoned, and the floodgates of morbid and romantic histology were opened. I think—mind, I say I *think*—the examiners have got enough mental detritus for twelve new handbooks. Note, now, the more remote effect.

The illustrious Walsham in his study, bringing out a new edition of the handbook, p. 161, "The method of union of Simple Fractures."

. . . . The granulation tissue, which is called cal—— (but no, I have promised Watson-Cheyne and Owen not to use that word; I'll make a fresh name later), consists here, as in the union of soft parts, of small round cells and of larger connective tissue and endothelial cells with a small amount of firm intercellular substance and delicate loops of capillaries, which are derived in part from the vessels in the Haversian canals and in part from the vessels in the periosteum, and adjacent soft tissues. It is found (1) replacing the periosteum and extending for some distance around the bone above and below the line of fracture, forming a spindle-shaped tumour, by which the ends of the fragments are surrounded, as it were, with a ferrule. (*Ensheathing or periosteal cal* —— (tut, tut; how careless of me!) "*substance which consists here, as in the union of soft parts, of small round cells and of larger connective tissue and endothelial cells, with a small amount of firm intercellular substance and delicate loops of capillaries*

which are derived in part from the vessels in the Haversian canals and in part from the vessels in the periosteum and adjacent soft tissues.")—Fig. 46 A.; (2) Replacing the medulla for some little distance up and down the medullary canal (*internal or endosteal ca*—— "*substance which consists here, as in the union of soft parts, of small round cells and of larger connective tissue and endothelial cells, with a small amount of firm intercellular substance and delicate loops of capillaries, which are derived in part from the vessels in the Haversian canals and in part from the vessels in the periosteum and adjacent soft tissues.*")—Fig. 46 B. (Pheugh, I am quite out of breath. Never mind, here goes again); and later (3) between the ends of the fragments (*permanent, intermediate or definitive ca*—— (I can't help it!) "*substance which consists here, as in the union of soft parts, of small round cells and larger connective tissue and endothelial cells, with a small amount of firm intercellular substance and delicate loops of capillaries, which are derived in part from the vessels in the Haversian canals and in part from the vessels in the periosteum and adjacent soft tissues.*")—Fig. 46 C.

The ensheathing callus and internal c—— (Oh, d—n it all, I can't get on. *Let* Rose and Carless bag the market, I don't care).

(*Curtain*). E.

Nursing News.

MATRON'S OFFICE.

It is with much regret we have to announce that Miss Cawley has resigned her post as Sister Charity, and left the hospital on Tuesday last. Her departure will be regretted by all here. Miss Cawley entered the hospital May, 1896, and most efficiently filled the posts of Night Sister and Ward Sister. For the present Mrs. Strathern is kindly taking charge of the ward, and we are all very pleased to see her amongst us again.

It is with much regret that Sister Constance, Miss Merriman, is leaving to join the Clewer Sisterhood. Though trained at Cambridge, and not at Guy's, she has won the affection of all the nursing staff here. Nurse Carey, Sister Violet, has been appointed Home Sister in her place.

On December 4th Nurse Ransford, Head Nurse in Astley Cooper ward, left the hospital having completed her three years' training. Probationer Graham has been appointed to succeed her as Head Nurse in Astley Cooper.

On December 4th Probationer M. W. Cooper was appointed Head Nurse in the Out-patient department, and succeeds Nurse Spedding, who is shortly taking up work at the Guy's Trained Nurses' Institution.

Sport.

Rugby Football.

GUY'S v. OLD MERCHANT TAYLORS.

(OLD MERCHANT TAYLORS, 1 GOAL; GUY'S, A TRY).

This match was played at Honor Oak Park on November 24th under inferior climatic conditions. Thomas kicked off for Guy's, and the ball going over our opponents' line they conceded a minor. O'Brian returning the drop out into the Merchants' twenty-five, Guy's began to press, and Orpen made a good run, of which full advantage was not taken. A short time later Morgan very nearly scored from a good opening by O'Brien, and Guy's, keeping up the pressure and passing well, McEvedy scored somewhat wide.

After the re-start the Taylors' forwards were seen to advantage, but good defence, in which O'Brien was very prominent, kept them from being dangerous. After a little time Guy's forwards relieved the pressure, and from a scrimmage half way Morgan relieved the ball, and bluffing those of his opponents he couldn't dodge made a lovely run, kicked over the full back's head, and nearly scored. Soon after this McEvedy got over, but the try was disallowed; half-time was then called.

In the second half it was soon apparent that some of our forwards had shot their bolt, whereas the Merchants played with renewed vigour, and kept up a fairly constant pressure until McEvedy relieved with a splendid kick, but Orpen in endeavouring to intercept a pass which was not given let one of the Taylor's half-backs through, who was running strongly when tackled by Harrison. After this the Taylors pressed strongly, and were only kept out by keen tackling; ultimately one of their half-backs, who throughout played well, succeeded in scrambling over about a yard from the touch-line, and Fletcher by a dramatic coup landed a fine goal. After this the game was very even, and ended in a win for our opponents by a goal to a try.

REMARKS.—In the first half the play of our backs left little to be desired. O'Brien in his new position was invaluable throughout, and Morgan's display as centre three-quarter was of a very high class indeed, while McEvedy was very sound. Orpen suffered from being unused to his confrères, but will prove no doubt a valuable acquisition. The forwards were excellent at times, but some found an occasional rest a necessity. On the whole we think the team as constructed for this match should make a good bid for the cup. Team:—

GUY'S.—E. M. Harrison (back); S. P. Wadson, L. J. J. Orpen, E. Morgan, P. F. McEvedy (three-quarter backs); A O'Brien, M. G. Louisson (half-backs); H. A. Cutler, R. C. Mullins, T. P. Thomas, R. C. Lawry, E. H. B. Milsom, B. Glendining, A. R. Thompson, A. H. E. Wall (forwards).

GUY'S AND ST. THOMAS'S v BLACKHEATH.

(BLACKHEATH, 3 TRIES; GUY'S AND ST. THOMAS'S, NIL.)

This match was played on the Rectory Field, on December 1st, under rather unfavourable circumstances. Rain during the week rendered the ground heavy and the field greasy. This at times greatly interfered with good passing. The Hospitals had the best of the first spell, but in the record they showed a sad want of form. Blackheath lost the toss and kicked off. After an exchange of kicks the ball was dribbled into the Hospitals' territory. Harrison, however, averted danger and gained a lot of ground with a splendid kick—a scrum resulted from the throw in and McEvedy receiving the ball made a dash for the line but was collared. Off side play, however, relieved Blackheath for a time. The Hospitals soon came on again with a loose rush but spoilt their dribble by kicking too hard. The Blackheath back, however, was splendidly charged down by Morgan, who would probably have scored had not an appeal for knock on been given against him. Several scrums followed, and eventually play was taken into the Hospitals' half. Blackheath then started several passing rushes but they were well stopped, Wetherell and McEvedy being conspicuous. Misunderstanding among the backs caused a scrum on the Hospitals' line but Devas relieved, and T. P. Thomas and Downes by good dribbling took the ball to Blackheath's end. The Hospitals now began passing rushes, but lack of combination and bad handling of the ball lost them their chances of scoring. Blackheath had to touch down. After the kick out play again settled in Blackheath's territory; nevertheless they began a passing rush which was well stopped, and almost immediately the Hospitals' backs began passing, with the result that Morgan was nearly in. Play continued in Blackheath's line until Wetherell had an unsuccessful drop at goal. Soon after this half-time was called with no score.

T. P. Thomas restarted the game and Blackheath at once took up the attack with a series of passing rushes. Trail and McEvedy were very much in evidence in defending their line. The Hospitals were, however, forced. Wetherell kicked out but the Hospitals backs were soon busy defending, and it was only bad handling among the Blackheath's three-quarters which prevented a score on one or two occasions. Soon, however, from a scrum on the Hospitals' line, the Blackheath forwards dribbled over and scored—no goal resulted. Shortly after this one of the Blackheath forwards retired hurt. After the kick out T. P. Thomas and Cutler dribbled well up the field where Cutler collared the back and a scrum resulted on Blackheath's line. Their forwards, however, broke away and carried the ball the whole length of the field; a scrum resulted and a splendid passing rush following gave Blackheath their second try which was not converted. After this the Hospitals rallied again and Mullins and Thompson were conspicuous in the loose. Several passing rushes took place in Blackheath's end and Morgan made some good runs—he should, however, have passed sooner on one or two occasions. Blackheath soon carried play back, and after some good passing they scored again. The kick at goal failed. From this to the end play was mostly on the Hospitals' line. No further score resulted, Blackheath thus winning by three tries (9 points) to nil.

REMARKS.—Harrison got through a difficult afternoon's work very creditably. The three-quarters had very little to do in the way of attacking. Morgan, however, ran well at times. McEvedy was splendid in defence, but had no attacking to do. Wetherell was in good form at half, but Devas was rather slow, both in passing and in tackling. The forwards all played splendidly, but Trail Thompson and Mullins were particularly noticeable for good play. Team:—

HOSPITALS.—E. M. Harrison (back); E. Morgan, L. J. J. Orpen, W. J. Evans, P. F. McEvedy (three-quarter backs); F. C. Wetherell, H. C. Devas (half-backs); R. C. Mullins (captain); D. H. Trail, T. P. Thomas, H. A. Cutler, A. H. E. Wall, R. J. C. Thompson, T. W. Downes, J. Wallace (forwards).

GUY'S 2ND XV. v. ROYAL NAVAL SCHOOL OLD BOYS.

Played at Eltham, on November 3rd, 1900, and resulted in the closest game of the season. The Old Boys opened the scoring by a try which was not converted, which H. S. Brown equalised soon after by scoring for Guy's; the extra points were not added and the score at half-time remained at 1 try each.

On resuming play, play was very even, till, owing to bad play on Guy's part, the ball was carried into their twenty-five; it was then that Guy's woke up, notwithstanding the fact that they were scrumming on their own line, by degrees carried the ball out of danger. Just before time, Hicks secured the ball and scored a very good try between the posts, Bridger adding the two points. Team:—

GUY'S.—R. D. Bridger (back); E. N. Jupp, S. L. Pallant, J. T. Hicks, H. S. Brown (three-quarters); A. E. Kynaston, Lindsey Woods (half-backs); N. B. Odger, A. S. Moon, P. M. Rendall, H. D. Smart, W. Layton, F. A. Beattie, G. Humphreys (forwards).

GUY'S 3RD XV. v. KING'S COLLEGE ENGINEERS 2ND XV.

(GUY'S, 17 POINTS; KING'S COLLEGE ENGINEERS, NIL).

Played at Wormwood Scrubs, on November 17th, in wretched weather, and resulted in a victory for Guy's by 17 points to nil. Bubb secured two tries, and Roper, Smith and Marshall one each. Brydone converted one. The forwards played a collectively good game, wheeling the scrums well, and doing some very effective rushes. There were, however, some glaring cases of picking the ball up, thereby spoiling good dribbling. The three-quarters must learn to stop forward rushes by securing the ball, *not* by taking loose kicks at it in any direction, preferably away from "touch." Team:—

GUY'S.—J. J. Gardiner (back); C. H. Reinold, W. H. urney, C. H. Bubb, M. R. Smith (three-quarter); R. S.

Roper, J. M. Brydone (halves); T. B. Layton, W. W. Jones, L. D. Stamp, F. A. Beattie, R. O. Williams, R. P. Marshall, L. Doudney, G. Humphreys (forwards).

Association Football.

GUY'S HOSPITAL v. RAMSGATE (ST. GEORGE'S).
(DRAW, 0–0).

Played on Saturday, November 24th, 1900. Guy's arrived one man short, owing to Edey missing his train. After raising a sub., the game was started at three o'clock. Ramsgate put a strong team on the field, including two old Blues.

During the first half, Ramsgate gave us a lot of trouble, but the halves and backs were equal to the occasion. The forwards, however, never made any good combined attacks, though once or twice they came near scoring. Nothing had been scored by half-time.

On changing over we had somewhat the better of the game. Chignell once got clean away, but made a very weak display in front of goal. Wilson, at outside left, played a good game, his centres being at times brilliant. Both sides tried hard to score, but our defence was too good for their forwards. Collins, in goal, played in his usual neat style. At half Goss played hard and was very useful, but he must look more where he passes, and not keep the ball too long. Bacon, on the right, played a fine game, being always on his man. The game ended, after a hard tussle, in a draw, there being no score. Team:—

GUY'S.—E. A. Collins (goal); W. M. Robson (capt.); H. Hogarth (backs); H. Bacon, J. Goss, N. P. Shepherd (halves); sub. N. F. Langdale, T. A. Chignell, C. Rust, T. F. Wilson (forwards).

GUY'S 1ST XI. v. TOWNLEY PARK.
(SURREY SENIOR CUP, 2ND ROUND).
(GUY'S, 3 POINTS; TOWNLEY PARK, 1 POINT).

This match was played at Dulwich on December 1st, and resulted in a win for Guy's by 3–1. We were handicapped in having both our backs away ill—Robson and Wells. Townley kicked off on a heavy ground before about 700 spectators, and pressed slightly, but throughout the first half the game was very level, neither side scoring. Barber should have scored from a centre from Norton, having only the goalkeeper to beat, but the ball was hard to control, being very slippery. Immediately on re-starting we got down, and Chignell scored from a centre of Wilson's in the first minute. After about five minutes Townley equalised, Collins having no chance to save. After pressing for some time, however, we regained the lead, Norton scoring with a good shot. From now we had considerably the better of the game, their goal being continually in danger. They, however, attacked once or twice by means of free kicks; from one of these Norton obtained possession, and outpacing the backs, scored a third goal. Time was shortly afterwards called, leaving us winners by 3–1.

The whole team played well, more especially Norton, Barber, Bacon and Shepherd. Edey played much better at back than he has at forward this season. Team:—

GUY'S.—E. A. Collins (goal); T. Edey, A. D. Crofts (backs); H. Bacon, J. Goss, N. P. Shepherd (halves); H. M. Langdale, H. Barber, T. A. Chignell, E. L. Norton, T. F. Wilson (forwards); H. P. Wiltshire (linesman).

GUY'S 2ND XI. v. BECKENHAM 2ND XI.
(GUY'S, 2 GOALS; BECKENHAM, NIL).

Played at Honor Oak Park on Saturday, October 27th. Guy's, playing with the wind, had all the better of the first half, though only one goal was scored, Dent obtaining it. Peall added a second, soon after the interval, by a fine piece of individual play. Nothing further was scored, and a poor game ended in a win for Guy's by two goals to nil. Team:—

GUY'S.—Binns (goal); A. Leeming, J. Braithwaite (backs); J. Reynolds, W. Henderson, P. P. Cole (half-backs); H. L. Dent, A. H. Bell, Wight, L. Smalley, P A. Peall (forwards).

GUY'S 2ND v. PARTHIANS.
SURREY JUNIOR CUP, THIRD ROUND.
(GUY'S, 1 POINT; PARTHIANS, 2 POINTS).

On Saturday, November 24th, the above tie was played at Earlsfield against the Parthians. Having won the toss, our opponents elected to play downhill and with the wind. With these advantages they soon began to press, but the defence relieved, and the play soon became fast. Several times Peall, on the left wing, got well away with the ball and centred, but the centre and insides failed to make anything. Profiting from one of these mistakes, the opposing forwards made a rush and scored.

Play after this was of an even character, in spite of the temporary absence of Carter, our goalkeeper, owing to a damaged knee.

Just before half-time, the Parthians added another goal, and the whistle went with two to nil against the Hospital.

Immediately on recommencement, our forwards pressed, but only managed to get through once, Cameron scoring. From that time till the end we potted at that goal, but without success, and the game ended in a loss for the visitors by a rather narrow margin.

Peall and Dent played good games, but the rest of the forward line was weak, particularly in front of goal. The halves tackled well, but their passing was inaccurate. In the defence, Braithwaite and Carter both exhibited pluck and judgement. Team:—

GUY'S.—H. H. Carter (goal); J. Braithwaite and A. Leeming (backs); P. P. Cole, A. D. Crofts, C. D. Pye-Smith (halves); P. A. Peall, —. Penford, J. Cameron, W. O. Roberts, H. L. Dent (forwards).

Reviews.

The price of books submitted for review should in every case be stated.

A Manual of Midwifery. By Dr. Galabin. Fifth edition. (J. & A. Churchill, London, 1890.)

The general features of this manual are so well known that it is quite unnecessary for me to refer to them. At the same time, this fifth edition deserves more than a passing note as it contains many new points of interest. I would first draw attention to a series of micro-photographs, illustrating retained placental tissue, vesicular mole and deciduoma malignum, and indicating, as Dr. Galabin points out, a gradation between these three conditions which at first sight have so little in common. The active proliferation of the syncytium covering the chorionic villi in some cases in which the ovum has been dead for some time is, so far as my observations go, an undoubted fact, and goes far to explain the genesis of one variety of deciduoma malignum more aptly described in this case as a chorionic epithelioma. To the chapters on these different diseases and more particularly to that on deciduoma malignum, I would like to draw attention as indicating the care with which the present edition has been brought abreast of modern scientific knowledge. The chapter on the placenta has been revised and now incorporates the views of the most recent workers on this subject. Dr. Galabin has re-written the chapter on extra-uterine pregnancy and has given us a good account of this by no means rare abnormality, and has laid down in his usual clear manner the different lines of treatment that are called for by the varying circumstances of the case. In the treatment of accidental hæmorrhage, the latest mode of dealing with these cases as practised at the Rotunda is introduced; that, namely, of plugging the vagina in cases in which pains are not present or are slight. Not only the reasonable grounds on which this method of treatment is based, but also the success attending its performance justifies its insertion. Elsewhere important alterations and additions are made, and in fact Dr. Galabin has done everything to ensure his book maintaining the position it has assumed as first of its kind. Lastly, Messrs. Churchill are to be congratulated on the improvement that they have effected, not only in the type and paper, but also in the shape of the volume.

G. B. S.

Appointments.

MR. C. H. BRANGWIN has been appointed Obstetric Resident from November 16th.

CIVIL.

CARTER, A. H., M.B. Lond., L.R.C.P., M.R.C.S., has been appointed Assistant Medical Officer to the Infirmary, Lewisham Union, *vice* J. Dunston, resigned.

DAVIES, HUGH, F.R.C.S. Eng., M.B., B.S. Lond., has been appointed Surgeon to the Miller Hospital, Greenwich, *vice* L. Moore, F.R.C.S. Eng., deceased.

DURHAM, FREDERIC, M.B., F.R.C.S., has been appointed Consulting-Surgeon to the North-West London Hospital, Kentish Town Road, N.W.

HAM, B. BURNETT, M.D., M.R.C.S., L.R.C.P., D.P.H. Camb., has been appointed Commissioner for Public Health, Queensland, Australia.

JUDGE, E. MACDONALD, L.S.A., has been appointed Medical Officer to the Ancient Order of Foresters (Court Sympathy), *vice* F. Smith.

MARTIN, D. A. W., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer at Fort Jameson, Rhodesia.

POLLOCK, R. G., M.R.C.S., L.R.C.P. Lond., has been appointed Medical Officer for the Tenth District of the Croydon Union, *vice* H. Rose Todd, L.R.C.P., L.R.C.S. Irel., resigned.

STURGES-JONES, W. E., M.R.C.S. Eng., L.R.C.P. Lond., L.S.A., has been appointed Medical Officer to the London and Pacific Petroleum Company, Talara, Payta, Peru, South America.

THOMAS, JABEZ, F.R.C.S. Eng., L.R.C.P. Edin., L.S.A., has been appointed Consulting Surgeon to the Swansea General Hospital.

TODD, D. B., L.R.C.P. Lond., M.R.C.S., has been appointed District Medical Officer, Westbury and Whonwellsdown Union, *vice* G. G. Parsons, resigned.

NAVAL AND MILITARY.

Surgeon GEORGE E. DUNCAN is appointed to the *Renown* and Surgeon HERBERT R. H. DENNY to the *Magnificent.*

Captain S. E, PRALL, Indian Medical Service, having completed twelve years' service is promoted to be Major.

Surgeon-Major DAVIS, Imperial Light Horse, has landed at Plymouth, invalided from South Africa.

Surgeon ROBLEY H. J. BROWNE, R.N., is promoted to be Staff-Surgeon for his services during the recent operations in China.

Mr. HARRY FULHAM-TURNER is appointed Surgeon-Lieutenant in the London Companies of the Volunteer Medical Staff Corps.

Birth.

BEVEN.—On December 4th, at 31, Balham Hill, S.W., the wife of Octavius Beven, M.D., D.P.H., of a son.

Marriage.

TRESIDDER—GARDEN.—On November 21st, at the Parish Church, Dalton-in-Furness, Morton Everard Tresidder, M.R.C.S., L.R.C.P. Lond., of Westcombe Park, Blackheath, London, to Elsie Annie, daughter of the late James Garden, Hamilton House, Dalton-in-Furness.

Death.

BEARDSLEY.—On November 20th, at the Towers, Grange-over-Sands, Amos Beardsley, M.R.C.S. Eng., aged 78 years.

ED.—S. H.

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Calendar of Coming Events.

December, 1900.

Sat. 22.—Messrs. Lucas and Lane's take-in; Drs., M. A. Collins and A. H. E. Wall; Cl., F. W. Sime.

Tues. 25.—Christmas Day. Concert in wards. Out-patients' tea.

Wed. 26.—Boxing Day. Medical Office closed.

Thur. 27.—Messrs. Golding-Bird and Dunn's take-in: Drs., M. Coplans and D. S. Graves; Cl., M. D. Wood.

January, 1901.

Tues. 1.—Lectures resumed.

Thur. 3.—Messrs. Jacobson and Fripp's take-in; Drs., M. W. Cohen and W. H. Bowen.

Sat. 5.—1 p.m., Clinical lecture by Dr. Shaw.
G.H.R.F.C., I., Old Leysians, away.
II., Rosslyn Park, home.
G.H.A.F.C., I., Old Eastbournians, home.

Guy's Hospital Gazette,

DECEMBER 22, 1900.

Pneumonia.

CLINICAL LECTURE BY Dr. PITT,
October 20th, 1900.

Gentlemen,—We have at the present time a large number of cases of Pneumonia in the wards, and there is no disease which gives rise to more anxiety, and none about which we have greater difficulty, both with regard to the early diagnosis and the line of treatment to be adopted. Consequently, it is very desirable that from time to time we should review our knowledge with regard to these questions of diagnosis and treatment.

It is difficult to classify pneumonia satisfactorily, but for practical purposes it is usual to divide cases into the catarrhal forms and the croupous. Catarrhal pneumonia is simply a local inflammation of the lung, and will not come under our consideration to-day. By catarrhal pneumonia, we mean an inflammation in the alveoli, which is secondary to some other lesion which has started in the bronchii, spread to the alveoli, and filling them with catarrhal products has led to consolidation. Being a secondary mischief, it varies very much because of the number of diseases with which it may be associated. It may develop in the course of bronchitis, pyæmia, measles, whooping-cough, influenza and many other lesions. In children, this is by far the most common form of consolidation of the lung which occurs, and it is also a form which again becomes very prevalent in the later years of life.

The other form of consolidation of the lung, which we speak of as croupous pneumonia, is one which may be met with at any period of life, which starts with extreme suddenness and rapidly incapacitates the individual attacked, and is the cause of a very considerable mortality, producing perhaps 6 per cent. of all the deaths that occur. Practically, you will find in the adult, that a croupous pneumonia, *i.e.* one in which the alveoli become filled with a fibrinous exudation; and a lobar pneumonia, that is, a consolidation occupying a whole lobe, are identical. But in children under the age of seven you may have a whole lobe consolidated, and yet microscopically, the alveoli will be filled with catarrhal small products, consisting of proliferated epithelial cells, with but little fibrin. So that, while in adults, croupous and lobar pneumonia are identical; you should consider that in small children, all forms, whether lobular, or lobar; are catarrhal, and do not microscopically differ, although to the naked eye the section of the lung shows much more uniform affection in the latter.

A. With regard to croupous pneumonia there is the very important question, both from the point of view of treatment and also of classification, whether it is a *specific disease*, or simply a local disease of the lungs? Much evidence of recent years has been adduced to show that it is a specific disease and not simply a local consolidation of the lung. In favour of the view that it is a specific infective disease:—

1. There is, in many cases, an absence of any apparent cause for the development of the pneumonia.

2. *Diarrhœa and vomiting* with great digestive disturbance are often marked, before the lungs show much evidence of being affected.

3. The constitutional symptoms may precede the development of any signs in the lung.

4. In the majority of cases the invasion is very sudden.

5. When the crisis occurs, the physical signs will often continue to develop, and there is no relation between the severity of the constitutional disturbance and the amount of lung which is involved.

6. Occasionally the disease occurs in several patients in the same house, and from time to time epidemics in a village have occurred, and occasionally, apparently, the disease has spread from one patient to another. There was a striking case of this last in the hospital about two years ago. A woman died with pneumonia, and the patient who was next admitted into the same bed with a totally distinct disease, within forty-eight hours developed pneumonia and also died. It seemed quite possible that in this case the infection had spread from the one patient to the other, although all the usual precautions in changing the bedding, etc., had been taken. The general trend of the evidence makes us conclude that it is wise to look upon croupous pneumonia as a specific infective disease.

B. Is there a *definite specific cause?* Now there was considerable difficulty in the bacteriology of the disease at one time, owing to the fact that the bacillus which was first described by Friedlander as being present; was on further examination, found in less than 10 per cent. of the cases; and that much more commonly (90 per cent.) a diplococcus, as pointed out by Fraenkel, is present. These organisms bear a superficial resemblance to one another, but while Friedlander's is easy to cultivate and does not stain with Gram's method, the other stains readily, but is difficult to cultivate. While, therefore, in most cases of croupous pneumonia the organism found is Fraenkel's, we must allow that pneumonia may also arise from other causes.

For instance, in a certain number of cases of typhoid, pneumonia develops; so also in plague, rheumatism, influenza, variola and phthisis. The whole question has not been sufficiently worked out as to whether Fraenkel's organism is always present in these cases, but it is almost certain that in typhoid and plague the consolidation is directly due to the specific organisms of those diseases. With regard to rheumatism, I think the evidence is strongly in favour of view that the consolidation which sometimes occurs is not always due to pneumococci. So that while, on the one hand, the great majority of typical cases are those due to Fraenkel's pneumococcus, we may get cases which resemble them clinically, but which are due to other organisms.

C. There is another difficulty, namely, that some patients present all the constitutional appearances and the disturbance which we associate with pneumonia, and yet in them consolidation of the lung never develops at all. In some of these cases no physical signs are noticeable. It may be, that the consolidation is in the centre of the lung and therefore not detectable; but it is found that pneumococci may set up not only consolidation of the lung, but, with or without any consolidation of the lung, may produce empyema, ulcerative endocarditis, meningitis, or suppurative peritonitis, of which last named there now are a few well authenticated cases. Pericarditis occasionally occurs as having spread from consolidation of the lung due to pneumococcal pleurisy, but I do not know that it has been recorded without any affection of the lung. The question is therefore complicated by the fact, that all these other lesions, as well as the disease, which we look upon as the specific consolidation of the lung, may be produced by the same organism.

The same difficulty occurs with regard to many diseases. The more we learn about the etiology of disease, the more we realise that there are few diseases which are due to a single cause. Most diseases are attributable to a concomitance of two or more disturbing causes.

In the case of pneumonia, for instance, it is extremely doubtful if any absolutely healthy person will develop the disease. Pneumococci are present in the fauces and mouth of a very large number of people, and yet give rise to no symptoms at all, and therefore it is not the mere presence of the pneumococcus that produces pneumonia, but some other cause is necessary which interferes with health, and allows them to develop.

As to epidemics or groups of cases, Sir Samuel Wilks used to refer to the case of a man who had died of pneumonia; his brother who was in perfect health came to his funeral, developed pneumonia, and also died. More than once a house exposed to effluvia from a sewer has had a series of three or four cases of pneumonia develop, and when the sewer gas has been cut off from the house, the attacks of pneumonia ceased; suggesting that the health of the inhabitants was undermined by the sewer gas,

and in that way their condition became suitable for the development of pneumonia.

Pneumonia occurs throughout the greater part of the world, and that it is not simply due to exposure to cold, is shown by the fact that, in the case of Polar expeditions, although men have been subjected to great vicissitudes, very often having had their clothes sopping wet, night after night for months together, and though in many cases they have had insufficient food; yet, even under these unfavourable conditions, such a disease as pneumonia is practically unknown. In the same way, in Switzerland, though a man who is climbing may be out for hours exposed to intense cold and on the sides of the most exposed peaks, he does not develop pneumonia. In some countries, pneumonia is much more common than in others, but it is not solely a question of the temperature of the place. For instance, along the Mediterranean, pneumonia is quite as common as in the north of Europe, yet in Egypt it is very rare. At sea, out in the ocean, it is extremely rare for anyone ever to develop an attack of pneumonia; yet during short voyages such attacks are not infrequent. With regard to statistics in the navy, it has been shown that sailors more often get pneumonia on land than at sea, and yet the probability is that they are more exposed to bad weather at sea than on land.

Pneumonia is more common and more fatal in towns than in the country. But this is not all, for in Cork the mortality per thousand inhabitants is only $\frac{1}{2}$ per cent.; in London it is 1·7; in Paris, 2·3; Algiers, 4·3; clearly showing that it is not a mere matter of temperature, but a question largely of hygienic conditions. Having referred to the absence of pneumonia in Polar expeditions, I might also draw attention to the fact that, of a body of French troops, who were quartered on Mount Cenis, one winter, from December to May, in overcrowded quarters, one fourth of the whole body developed pneumonia. Pneumonia often occurs as an epidemic in prisons: and when they are overcrowded, this disease is a common cause of mortality. You cannot too thoroughly get the idea into your head that pneumonia is not merely due to exposure to cold. It is very important that that view should be appreciated, because one of the most essential factors in the treatment of pneumonia is, that the patient should not be shut up in a stuffy room, but should have plenty of fresh air; the bedroom window should be left open, and the treatment should be exactly on the opposite lines to what the friends generally carry out. Bedclothes should not be heaped up; sponging is often desirable; while cold bathing and ice poultices are sometimes indicated.

It is somewhat difficult to determine from statistics the mortality due to pneumonia, because in the Registrar-General's returns a large number of cases reported as pneumonia are undoubtedly due to bronchopneumonia. According to his returns the mortality is far greater in children under five years of age than afterwards. Now, while it is no doubt true that you do get a certain number of cases of pneumonia, that is to say, an acute consolidation of a whole lobe, in children; yet in the great majority of cases, the disease supervenes on a bronchopneumonia.

Your prognosis in such cases depends largely on the previous nutrition of the child, and whether the case has followed upon a bronchopneumonia; rather than upon the amount of consolidation. If you have a young, well-developed child without any bronchopneumonia, the prognosis of a lobar pneumonia in such a case is good; but if the pneumonia supervenes upon a chronic bronchopneumonia, then it is a very potent cause of mortality. With each decade the mortality from pneumonia increases in proportion to the number of persons living at each age. For instance, between the ages of ten and twenty the mortality is about 8 per cent., between twenty and thirty, 12 per cent.; between forty and fifty, 29 per cent., and amongst persons of seventy years of age the mortality mounts up to 50 per cent. But a fairly healthy young adult who is free from kidney disease, and who is not a chronic drunkard, almost invariably does well. With adult patients, between twenty and forty years of age, your prognosis very largely depends upon the fact as to whether they are alcoholic or not.

One great cause of death amongst chronic alcoholics is certainly pneumonia. It is very difficult to determine what amount of mortality is due to chronic alcoholism; that is, with reference to persons who are most indignant if you suggest that they are ever drunk, but at the same time they are rarely dry. Such persons are extremely bad patients for acute diseases, and particularly for pneumonia. In the hospital I should think that three-fourths of the cases that come in with acute pneumonia occur in alcoholic patients.

I want now to read you the notes of some of our cases before we go on to discuss the more interesting symptoms. We have had a great many cases, but I am only going to draw your attention to four. Two of them are a boy of ten and a girl of sixteen who developed a typical pneumonia; and in whom, from the beginning,

the prognosis was absolutely favourable. The third case was a not very well-nourished boy, in whom the disease from the very first ran an anomalous course, and who finally developed empyema. The fourth case is a man of twenty-four who has been most probably in the habit of taking too much alcohol, although he will not plead guilty to having more than three or four glasses of spirits in the evening; and about whom from the very first we gave a very bad prognosis, because his pulse was 120.

First of all, with regard to the boy ten years old. He was taken ill on the 27th with epigastric pain, shivering, headache, and vomiting. The onset was sudden. When admitted on the third day he had no physical signs. On the fourth day he had a furred tongue, and an impaired note was detected in the right axilla with a rub and a few crepitating râles. His urine had not the faintest trace of albumen. On the fifth day the breathing began to get of a whiffing character and gradually became tubular. The consolidation extended, and by degrees the whole of the right lung became dull, with tubular breathing, consonating râles, and broncophony. The boy was very flushed and cyanosed, he had a great deal of distress, with dyspnœa and rapid breathing. He took his nourishment well, and after he had been in nine days, his temperature came down, the symptoms subsided, and he convalesced. This is a typical case, without any complication. The temperature at the onset was 103.4°, and never ran excessively high, and gradually coming down, at the end of a week fell to normal. The boy had a pulse of 120 or 130, but in dealing with children you should always form your prognosis from the appearance of the child; because it is comparatively rarely that a child is dangerously ill, without appearing to be so. In adults this is not true; but a pulse of 120 or 130 in a small boy who looks fairly well, need give rise to no anxiety. Had the case with this rapid pulse been that of a man, your prognosis would have been totally different.

The next case, is the girl of sixteen who woke up suddenly one night (October 8th) with an intense pain in the left chest. This gradually increased, and when she came into the hospital three days later, she had a rub in the left axilla with a few crackling râles and the commencement of bronchial breathing at the angle of the scapula. The physical signs of pneumonia may remain in abeyance for two or three days, but whenever consolidation begins anywhere near the lower part of the scapula the physical signs develop quickly. There is a large bronchus which runs down here within only about half an inch of the surface of the lung; and a very small amount of consolidation near it will give rise to marked physical signs, so much so that you must always discount any physical signs which you notice there. The girl had great dyspnœa and distress, she was very cyanosed, but her temperature came down gradually and she recovered within ten days of admission. In her case the lung became more consolidated after the temperature fell, and even now the signs have not altogether cleared up. There is nothing very special to which your attention need be drawn in these two cases.

The next case is the boy with empyema. He is seventeen years old. He had been taken ill on the 15th of September with a headache and severe pain in the left side, so that he was hardly able to walk. He had a cough and became slightly delirious on the third night. When he was admitted he had complete dulness from the spine of the scapula downwards on the left side, with a few consonating râles in the axilla, but without any bronchial breathing. Over the posterior surface of the chest, from the sixth rib downwards, there were consonating râles and bronchial breathing. The consolidation gradually extended. At the end of about ten days the patient's temperature came down considerably; it never was up above 103°, it usually was 102° to 101°, and at the end of a week it dropped down to 100°. Instead, however, of falling to normal, as is usual, it remained between 100° and 101° for the next ten days or a fortnight. Now the change in the physical signs which corresponded to this pyrexia, consisted of a gradual improvement in the note at the base, so that, instead of a completely dull note, there came to be simply an impaired resonance; the tubular breathing persisted for some time, but gradually became less marked. During the first days in October the note at the apex began to become more impaired, and gradually became increasingly so. There was at one time a certain amount of tubular breathing, with increased voice sounds at the apex, but in the course of the first few days of October the breath and voice sounds at the apex became diminished. So that the patient presented dulness at the apex with an impaired note at the base and deficient breathing at the apex, with indeterminate breathing at the base.

The question therefore arose, Was this increasing change at the apex of the lung due to some phthisis which was clearing up, or due to a spread of the pneumonia, or to an empyema?

There was a little uncertainty for about three days, but, after five days, it became quite clear that the signs pointed to a localised empyema forming at the upper part of the lung. On exploring, on the 7th, it was found that there was a collection of pus which occupied the front of the chest and also the axilla, the lung at the base not having completely collapsed, and therefore the fluid was pushed up towards the upper portion. The chest was drained and pus was removed from an opening in the fourth space in the axilla. The fluid which was removed was that which you invariably find in these pneumococcal cases, that is to say, pus with a large amount of lymph, the latter sometimes amounting to several ounces, and you do not meet with these large masses of lymph in empyema in any cases except those connected with pneumococcal infection. The examination of the fluid went to show that it contained streptococci as well as pneumococci, but undoubtedly the main cause was a pneumococcal infection. Although the chest has been opened ten days, the lung is not expanding satisfactorily. Both in pneumonia and in typhoid the result of the disease is very largely to reduce the elasticity of the lung.

The recovery of a lung, after having sustained severe pressure, depends on its elasticity, and in such a case as the present, where the lung has been very much damaged by the pneumonia, it not infrequently happens that, although you may draw off the fluid, the lung will not rise up to fill the space. The cavity of the chest on the left side is diminished as much as possible by the secondary changes that have taken place in the thorax; that is to say, the diaphragm has risen considerably so that it is now as high as the fourth rib. The vertebræ are bent over so that there is lateral curvature with the concavity toward the left, there is dropping of the scapula and of the shoulder, and the ribs have fallen in, so that that side of the chest is very much smaller than the other. Still, in spite of all these changes, the space which is unoccupied by the lung, between the lung and the thoracic wall, is considerable, and the recovery will probably be a very protracted one.

The last case is the most serious of all. The patient is a tanner, a man of twenty-four. He was perfectly well until midnight on the 13th of October, when he woke up with intense pain in his epigastrium. The pain was so severe, and the rigidity of the abdomen so great, that even when he was admitted there was a question as to whether the lesion were a thoracic or an abdominal one. It is not at all infrequent to find that the pain due to pleurisy is referred to the extremities of the nerves which are being irritated, and consequently the pain instead of being referred to the chest, is referred to the region of the umbilicus. Therefore, you have always to bear in mind, when a patient comes up with great abdominal pain, that one of the possible causes is pleurisy, and very probably the surface of the diaphragm is involved. In such cases the abdomen is held very rigid so as to prevent the diaphragm from moving. The patient thus affected not infrequently has vomiting, when the distress and pain from the diaphragmatic pleurisy is so great that very often the question of perforation is raised.

On examining the man, all that could be made out, in physical signs, was a slightly impaired note at the angle of the left scapula, with a little whiffing breathing, and even a day later the physical signs were not very much more marked. But on the 16th he was suddenly seized with intense, agonising pain, causing him to scream out, and it was very much worse than what he had had previously. On listening, you found that the chest was scarcely moving at all, that there was a rub audible all over the axilla, and there was no doubt that the pleurisy had extended very considerably.

When this man was admitted his pulse was 130, his temperature only 101°, and his respiration 36. He was extremely dyspnœic and very collapsed, and even when he quietened down and stopped in bed his pulse did not drop appreciably. On one or two occasions the pulse was as low as 116, but very often it was up to 124. Now a young man with a pulse of 120, and a temperature only moderate in amount, although all the other physical signs and all the other appearances may suggest that the man is not very seriously ill, very often dies before the end of the attack. You should lay it down as a rule for guidance that a man with pneumonia, who has at the early stage a pulse of 120, runs the very gravest risk in the attack which is commencing.

On the 19th his pulse suddenly ran up to 150, although his tempetature was only 100°, and there is no worse element in prognosis than this combination of a falling temperature and a rising pulse. Pneumonia, as you know, very often proves fatal just about the time of the crisis, and those cases in which, as the temperature comes down the pulse runs up, ought always to be watched with the greatest scrutiny, because, unless you stimulate them very vigorously, they are very apt to slip through your

fingers. In this man the consolidation of the lung is spreading, his pulse remains extremely bad, and I am very uncertain as to whether we shall be able to save him.

[He has died since the lecture was delivered, and in addition to pneumonia of the left lung and diaphragmatic pleurisy, there was also pericarditis, which was not detected during life, as no pericardial friction sounds could be detected amidst the loud râles and friction sounds in the chest.]

Now this group of cases present features illustrating the various features of pneumonia, and we will, for the rest of the time we have, discuss one or two of the more important symptoms.

First of all, with regard to the typical symptoms which are generally suggestive of pneumonia. One of the most constant is the perversion of the respiration and pulse ratio. Normally the ratio between the pulse and respiration is about 1 to 4, but in pneumonia you invariably find that the ratio is altered, so that it may be 1 to $2\frac{1}{2}$, or even occasionally the respiration may be almost as quick as the pulse.

The onset is almost invariably associated with pain in the chest, very often extremely severe.

In most cases there is pyrexia. When I say *in most cases*, you should bear in mind that old people will develop pneumonia with a perfectly normal temperature, and unless you make a careful physical examination, you may have them dying of pneumonia without your discovering it, because you expected the temperature to be raised. In young people and children it is not possible to have pneumonia with a normal temperature.

The most frequent combination of symptoms at the onset consists of sudden pain in the side, dyspnœa, pyrexia and disturbance of the respiration.

To these symptoms there is generally, superadded, either a rigor or vomiting. The pneumococcal poison often disturbs the alimentary canal as much as it does the lung, but the lesion to be found in the alimentary canal is usually comparatively small. The Peyer's patches may be swollen and there is often catarrh, but sometimes there is so much disturbance of the functions of the alimentary canal, as very materially to affect the prognosis.

Those cases of pneumonia which commence with vomiting have a higher mortality than those that start with a rigor. There may be no physical signs at all for a considerable period, but in the majority of cases there is some slight evidence within twenty-four hours either of a rub or of deficient breathing. If, as sometimes happens in exceptional cases, the physical signs do not develop for four or five days, it is very often difficult to make up your mind as to the diagnosis. But while the temperature and pain may be due to several conditions; the disturbance in the respiration is a symptom which may very often give you a clue as to what disease is developing. In children particularly the character of the breathing is an important index. Normally, in a child, a pause occurs at the end of expiration, but when pneumonia develops, the pause takes place at the end of inspiration. This symptom is a very valuable one.

Pain. — In pneumonia the pain may be extremely severe, so severe as to cause even a strong man to become almost hysterical. It is usually a stabbing pain, like that caused by a knife. The pain occurs in the chest, and it may be so severe as to compel the patient to check his respiration, to hold his breath as much as possible, to breathe extremely shallow, to avoid talking, in fact to avoid any movement, and to take to his bed at once. There is no disease which illustrates what a blessing pain is better than pneumonia. Without pain, very often the patients would keep about and try to do their work, and probably end in killing themselves; whereas, owing to the pain, they are at once *hors de combat*, and are compelled to go to bed. The pain is most severe when the diaphragm is involved. There are very few pains more intense than that of diaphragmatic pleurisy. There is, at first, very little evidence of the affection of the diaphragm to be made out by physical signs. The patient is afraid to breathe or speak, but beyond the deficient shallow breathing, and the fact that he is extremely distressed, there is nothing more to be detected until the disease reaches the surface of the chest, when, of course, a rub may be heard. The amount of sensibility in the pleura varies very much, but when there is inflammation of the pleura, there is a greatly increased tenderness to pressure, and also a greatly increased cutaneous tenderness. With the increased cutaneous tenderness, you invariably find increased superficial reflexes. Such pain is best relieved by morphia, poultices and hot moist applications, and very often it is the most urgent symptom that you have to deal with at the commencement of the disease. But fortunately, within two or three days, the severity of the pain passes off, and it is rare to have severe pain as late as the end of the first week of the pneumonia.

The respiration is rapid, and there is often intense dyspnœa, but the two do not go together. A patient may be breathing very rapidly with very little distress; and *vice versa*.

The origin of the dyspnœa is not quite clear. It is certainly not due to the amount of lung involved, because the dyspnœa may be much greater at the commencement, when there is but slight involvement of the lung, than it is later on, when a large portion is consolidated. The dyspnœa is probably partly due to the poisoning of the respiratory centre by the toxæmic condition which is developed; or it is reflex due to the inflammation set up in the pleura, which, acting on the respiratory centre, gives rise to the dyspnœa. Thirdly, it may be due to the fact that owing to the pain the patient moves his diaphragm and intercostal muscles very slightly, and therefore there is more distress in consequence of the excessive work which the rest of the muscles have to do. But dyspnœa is almost always present, and is much more marked at the onset of the disease than later on, although rapid breathing, when there is extensive disease, may be very marked towards the latter part of the attack. When the crisis occurs, dyspnœa stops almost at once, although the lung may remain solid for some time, or, in some cases, the consolidation may even increase; but as the dyspnœa ceases, or, at any rate, diminishes very greatly, it clearly shows that it is largely due to a nerve disturbance and is not merely a mechanical one.

Cyanosis and lividity also occur. These are due to two causes, one being defective respiration owing to the large amount of lung which is damaged; and the other the toxæmic condition. A patient with phthisis, or a patient with pleuritic effusion, may have quite as much lung useless, but he will have nothing like the same amount of cyanosis.

The rigors and vomiting also are evidence of a general nerve disturbance. It is very rare for a rigor to occur except at the onset. If rigors or shivering occur later on, the probability is that there is either gangrene or abscess of the lung, thrombosis of some vessel, which occasionally occurs, or an empyema. But ordinarily rigors do not develop except at the onset of pneumonia.

I propose in my next lecture to continue the discussion of pneumonia and its treatment.

Chapel News.

The celebrations of the Holy Communion on Christmas Day and New Year's Day will be at 6, 7, and 8.45 a.m.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Taylor.

Mary	38.	? Enterica.
	39.	Fibroid lung. Enlarged heart. Mitral stenosis.
	40.	Typhoid. Peripheral neuritis.
	42.	? Hodgkin's disease.
	43.	Aortic and mitral stenosis and regurgitation.
	44.	Chlorosis.
	45.	Tubercular kidney. Nephrectomy.
	50.	Gastric ulcer.
Cot	56.	? Bronchitis.
Philip	22.	Phthisis.
	23.	Right hemiplegia. Aphasia.
	24.	? Carcinoma of stomach.
	25.	Aortic stenosis and regurgitation. Mitral regurgitation.
	26.	Double mitral disease. Bronchitis.
	27.	? Typhoid.
	28.	Mitral stenosis and regurgitation. Chronic peritonitis. Ascites.
	32.	Left pleurisy. Old right pleurisy. Peripheral neuritis.
	33.	Lead colic.
	35.	Acute rheumatism. 2nd attack.
	37.	? Fractured ribs. Pneumonia.
	38.	Abdominal abscess. Laparotomy.
	39.	Pseudo-hypertrophic muscular paralysis.
	40.	Aortic regurgitation.

Cases under Dr. Hale White.

Mary	13.	Cerebral tumour.
	14.	Acute osteo-arthritis.
	15.	Mitral regurgitation. Enlarged liver.
	16.	Cerebral tumour.
	17.	Typhoid. Arthritis. Dilated heart.
	18.	Acute rheumatism. Mitral stenosis and regurgitation.
	19.	Enlarged spleen. ? Cause.
	20.	Typhoid.
	21.	Right pleuritic effusion.
	22.	Carcinoma of cervix. Secondary deposit in spinal cord.
	23.	Chlorosis.
	24.	Diabetes mellitus.
Cot	53.	?
Cot	54.	Posterior basal meningitis. Recovery. Mental deficiency.
Philip	1.	Acute nephritis.
	2.	Appendicitis. Operation.
	3.	Diabetes mellitus.

Philip	4.	Fibroid lung. Pulmonary osteo-arthropathy.
	5.	Granular kidney. Acute tubal nephritis.
	6.	Granular kidney.
	7.	Typhoid.
	8.	Typhoid.
	9.	Carcinoma of liver.
	12.	Mitral stenosis.
	13.	Mitral stenosis and regurgitation. Enlarged liver.
	15.	Aortic stenosis and regurgitation.
	16.	Appendicitis. 1st attack.
	18.	Epithelioma of œsophagus.
	19.	? Cirrhosis. Gonorrhœal arthritis.
	20.	Acute rheumatism. Mitral regurgitation.

Cases under Dr. Fawcett.

Mary	1.	Chronic headache. ? Cerebral tumour.
	2.	Anæmia.
	4.	Rheumatism.
	6.	? Neurosis. Spastic condition of legs.
	8.	Gastric ulcer.
	11.	? Cerebral tumour. Chronic headache.
	12	Peripheral neuritis.
Cot	51.	Pyrexia. Broncho-pneumonia.
Cot	52.	Pleurisy with effusion.
Stephen	2.	Asthma.
	3.	Rheumatism.
	4.	Rheumatism. Aortic regurgitation. Bronchitis. Emphysema. Angina.
	5.	? Chronic bronchitis.
	6.	Bronchitis. Tricuspid and mitral disease.
	7.	? Typhoid.
	9.	Hydrox-herpetiforme.
	10.	? G.P.I.
	11.	Lateral sclerosis.
	12.	Pneumonia.
	13.	Typhoid.
	14.	? Appendicitis.
	15.	? Acute tuberculosis. ? Interlobar. Empyema.
	16.	Lobar pneumonia (right base).
	17.	? Caseous mediastinal glands.
	18.	Pneumonia.
	19.	Rheumatism. Mitral endocarditis.
	20.	Pneumococcal pleurisy.

In the Surgical Wards.

Cases under Mr. Howse.

Astley Cooper	4.	Concussion.
	18.	Fractured fibula.
	24.	Fractured tibia and fibula.
Job	9.	Tuberculous bursitis of tendo achillis.
	19.	? Anthrax pustules.
Lydia	12.	Rectal polypus.
Cot	B.	Scald of fauces.

Cases under Mr. Lucas.

Lazarus	15.	? Vesical growth. ? Calculus.
	17.	Encysted hydrocele of cord.
	19.	Ankylosis of knee. ? Urethral.

Cases under Mr. Golding-Bird.

Charity	15.	Varicose veins.
	16.	Old periostitis of tibia and necrosis.
Luke	10.	Glandular hypospadias.

Cases under Mr. Jacobson.

Cornelius	1.	Bullet wound in hand.
Dorcas	6.	Hæmorrhoids and prolapse of rectum.
	12.	Hæmorrhoids.
Naaman	1.	Kyphosis and chronic abscess of thigh.
	14.	? Growth of Bladder. Hæmaturia.
	16.	Inguinal bubo and venereal warts.

A Case of Aneurysm of the First Part of the Aorta Pressing on and Perforating the Superior Vena Cava.

William S., æt. 41, was admitted under Dr. Bryant on November 6th, 1900, for cyanosis and œdema of face, neck and arms.

Patient had been a soldier, and in 1879 contracted syphilis, for which he was *treated for a fortnight or three weeks*. In 1884 patient did ten months foreign service in Egypt, where he had dysentery and bilharzia. On leaving the army in 1886, patient joined the police force, in which he has been ever since. Of late he has been subject to coughs in winter, and during the last three months he has had slight attacks of cyanosis, with dizziness and shortness of breath coming on after stooping, but only lasting a few minutes.

History of present attack.—On Saturday, November 3rd, patient felt quite well, although he then noticed some cyanosis of ears after stooping. On Sunday he was just finishing his work at the police station, when he suddenly had a feeling as of a rush of blood to the head. He was now dizzy for a moment, and his eyes felt as if they were bursting. He then noticed that his neck and arms were swelling, and that his face was becoming blue. His ears he describes as being quite black. He was not short of breath. As he made no improvement, he came up to the hospital, and was admitted on Tuesday.

On admission.—Patient's face, neck, and arms were very cyanosed and somewhat œdematous. His expression was anxious, and he was most comfortable propped up in bed in a half sitting posture. Skin all over body was moist and covered with beads of perspiration. Veins over shoulders, arms, chest, and the temporal, were dilated and prominent. Severe frontal headache. There was no œdema or cyanosis of legs or feet. There was slight tracheal tugging, and the note at the right apex was somewhat impaired.

Circulatory system.—Cardiac impulse could not be seen or felt. Cardiac dulness diminished. On auscultation a soft systolic bruit could be heard at the apex, and in the aortic area there was a definite systolic bruit, loudest at the end of each inspiration. The chest was emphysematous. The urine was normal.

Progress.—Patient never improved. On November 9th a pustular eruption broke out over the back, and a bedsore was found on the neck.

November 13th.—Veins over chest more dilated. No pulsation could be detected. Pupils equal and react to light. Air entry on both sides good.

15th.—Breathing became more laboured. Patient became comatose and died at 6.30 p.m.

Treatment.—Mist. Hydrarg. et Pot. Iod. ʒj. t.d.s.

At the post-mortem examination a saccular aneurysm of the first part of the aorta, about the size of a tangerine orange, was found. It had pressed on the superior vena cava, which was markedly constricted, the walls showing inflammatory thickening. Just above the constricted portion was a small perforation, which was found to communicate with the aneurysm.

In reference to the above case, it may be interesting to note two specimens of a similar condition in the museum, viz., 1480^{65} and 1480^{66}, the latter of which has a similar clinical history as the above.

The interest of this case lay in the extreme degree of the cyanosis, and the absence of pulsation or regurgitant bruit in the aortic area, all of which were against a correct diagnosis.

Religio Medici.

The Bishop of Stepney's lecture in the chapel was well attended and listened to with great interest. He took as his subject: *Why do I believe in Christ?* and asked his audience to face this belief, which was a tremendous one, and could not help having a great influence over their lives. He gave four answers to the question:—

I. *Because Christ has been believed in from the beginning of the Church.* This can be proved from St. Paul's four undoubted epistles (Gal. I. and II., Cor. and Rom.). The lecturer quoted passages from each of these, which said that Christ was God, and he reminded his audience that these epistles were written before the gospels.

II. *Because it is a reasonable belief.* We should naturally expect that God would reveal himself to men. The theories of evolution had only made this revelation more wonderful. There was nothing in them to upset a christian's faith. It seemed to the lecturer a far greater thing that God should have created matter in such a way that it could become a watch than that He should create a watch straight off. Man was, on any theory, the crown of the visible creation, and it was reasonable to expect that God would not stop there, but go one step further, and give an object-lesson of what a man might be. Then, turning to Jewish prophecies and Gentile writings, we found such an expectation possessing the minds of the best men, *e.g.*, Plato in the *Phaedo*, questioning whether some divine word, stronger than the best of human doctrines, could not be found whereupon, as on a raft, men might reach the shores of truth.

Then, there was the preparation for the Incarnation in the spread of the Greek language over the Roman Empire, and also the significant fact that the Son of God appeared in Palestine, which was, for various reasons, the centre of the known world.

III. *Because Jesus Christ actually came.* The Bishop said that in his undergraduate days the doubt used to haunt him whether Christ was really a historical character. This could be set at rest by a reference to those passages in the heathen historians Tacitus and Suetonius, who bring His name and work into their histories. This belief was confirmed by seeing the effect that the historical records of Jesus' life had upon such men as J. S. Mill, Lecky and Napoleon.

IV. *Because of what He says about Himself.* Assuming that Christ was humble and sincere, what does He say about Himself? He makes a more tremendous claim than any other man has ever dared to make. "I am the Light of the world," "I am the Bread of Life," "He that believeth on Me . . shall never die," "He that hath seen Me, hath seen the Father," "Before Abraham was, I am," "My Father and I are *one thing*." With such words as these He stands before this generation and asks: What think ye of Christ? And the answer of Christians is: "Thou art the King of Glory, O Christ: Thou art the Everlasting Son of the Father." Having arrived at this answer, it is easy for us to give a rational account of the miracles. Being what He was it was natural that He should exhibit a greater control over nature than ordinary men. The miracles do not prove the Divinity of Christ, but *vice versa.* The Bishop here digressed for a moment, and advised his hearers to read Godet's *Defence of the Christian Faith* or Robbins' *Essay towards Faith.*

He concluded his lecture by pointing out the enormous influence for good which the body of christian physicians wielded in the nation, and uged his present audience to be true christians, and to follow their Master, Who went about doing good and healing all who were diseased.

Christmas Concerts.

The Christmas concerts have been arranged to take place in the wards as follows:—

	P.M.	
Wednesday, Dec. 26.	3 to 5.	Charity.
	5 to 7.	Stephen.
	6 to 8.	Cornelius.
Thursday, Dec. 27.	4 to 6.	Naaman.
	6 to 8.	Luke.
	6 to 8.	Lazarus.
Friday, Dec. 28.	5 to 7.	Dorcas.
	5 to 7.	Lydia.
	7 to 9.	Astley Cooper.
Saturday, Dec. 29.	3.30 to 5.30	Mary.
	5 to 7.	Martha.
	6 to 8.	Patience & Samaritan
Monday, Dec. 31.	6 to 8.	Job.

Reviews.

The price of books submitted for review should in every case be stated.

Operative and Practical Surgery. By Thomas Carwardine, M.S. Lond., F.R.C.S. (John Wright & Co.)

We strongly commend this book to the attention of students and practitioners; the former will find in its lucid illustrations valuable aid to their reading and work in the wards; the latter will be posted up in much that is novel. In its six hundred odd pages the book embraces such a wide field, touching as it does the subjects of bacteriology, minor and major operations, fractures, and the special departments of teeth, ear, throat and eye, that the author has aimed less at detail than at a general survey of the methods of treatment; but, by means of five hundred and fifty illustrations, most of which are from his original drawings, and also by a methodical system of comparative tables, he puts before his reader *multum in parvo* which appeals to the eye, and is on that account the more easily retained by the memory.

The section comprising bandaging, dislocations and fractures, is particularly worthy of perusal by the dresser, who may, however, have his own opinion as to some of the methods of after-treatment, as, for instance, that of Colles' fracture, of which the author says: "In children splints should be removed at the end of a month; in adults at the end of four weeks when impacted, and five when not impacted. Occasionally, passive movements may be commenced earlier."

The description of various operations is graphic and exact, special insistence being made on the necessity for scrupulous attention to asepsis; while the diagrams are so clear that they are self-explanatory of even Lawson Tait's flap splitting method of operating on ruptured perinæum. Letterpress is thus economised where possible, but is always good reading, and crisp in phrase and aphorism.

The special sections are written by well-known surgeons, that dealing with the eye, by F. R. Cross, being especially good, while the chapter on extraction of teeth contains hints which should prove useful to the surgeon as well as to his patient.

Refraction and How to Refract. By James Thorington, M.D. (Published by Rebman, Ltd.)

This is an American book by a member of the Philadelphian Polyclinic, giving a simplified account of the numerous methods of arriving at the various ametropic conditions found in common practice. It is well written, simply put, nicely printed, and is to be recommended to anyone commencing to study this subject.

The opening chapters treat of the elements of optics necessary for a complete understanding of the subject. Then chapters on the various varieties of ametropia, also on the ocular muscles, cycloplegics, applied refraction, and the book finishes with some practical hints about glasses, and how to order them.

There are numerous Americanisms in the letterpress, perhaps the most curious being that of the title, "Refraction and How to Refract." No light at all is thrown or can be thrown on this subject, since we have always thought that refraction was the property of transparent bodies.

A Manual of Surgical Treatment. By W. Watson Cheyne and F. Burghard. Part III. Price 12s.

This volume deals with the surgical affections of bones, fractures, and diseases, and amputations. It is the most interesting, and certainly the most useful to the junior men, of the three volumes yet published, and we recommend men who are doing their surgical dressing to read this volume if they do not find time to read the others. The methods of putting up fractures of all kinds are fully dealt with and much more explicitly than in the general text-books, from the time-honoured treatment by splints and plaster of Paris to the treatment by screws and wires. The volume is well illustrated and is in unison with the previous volumes of the same work.

A Handbook of Diseases of the Eyes and their Treatment. (Swanzy. Seventh edition. Price 12s. 6d.)

This book has been a favourite with Guy's men now for many years, and the present edition brings the work up to date, many additions and improvements being effected. One of the most important is an excellent description of the localisation of foreign bodies in the eye by Mackenzie Davidson's method—a method complicated and requiring time and accuracy of adjustment, but amply repaying the trouble by giving exact results, and having proved, as we know, of the greatest value in many cases.

The sideroscope, a delicately poised magnetic needle devised by Asmus, of Wiesbaden, for detecting foreign bodies in the eye, is also mentioned, but this instrument is quite supplanted by the X-Rays.

Some tables of the relative values of the various mydriatics, myotics and local anæsthetics used in ophthalmic practice, and the description of Dr. Mule's neat operation for ptosis, are new in this edition, and complete an excellent text-book, the only improvement we would suggest being that more diagrams and illustrations be inserted.

A Manual of Surgery. By Rose and Carless. Third Edition.

The third edition of this work is just published. It differs but slightly from the previous edition which was published only last year, a testimony to the popularity of this excellent text-book. The order of the chapters has been changed so that diseases and injuries of the same organs are no longer widely separated. Fresh and

more distinct skiagraphic plates have been inserted and the whole book revised.

The Pocket Formulary for the Treatment of Disease in Children. By Ludwig Treyberger, M.D. Vienna, M.R.C.P. Lond., etc. (London, Rebman Limited. 7s. 6d.)

The fact that a second edition of this little pocket book has been demanded in less than eighteen months is in itself sufficient indication of the real want which it fills. The present edition has been thoroughly revised, and the numerous errors which cannot fail to appear in a first edition have been studiously corrected. To the student and general practitioner alike this little book cannot fail to be of great help when he is confronted with one of the never-ending phases of childish ailments. The small size of the book and the flexible covers make it peculiarly convenient for carriage in the pocket.

Diseases of Women. (Bland, Sutton & Giles).

The introductory passages of this little book on Gynæcology are devoted to the anatomy of the generative organs, followed by a description of the more common instruments used in examination. In the part devoted to the instruments, the descriptions are brief and in some cases scarcely sufficient.

The chapter on Hermaphrodism is clear and concise, dividing the sexual characteristics into primary and secondary, showing how difficult often it is to determine the sex, and with the onset of puberty how valuable are the secondary sexual features in arriving at a correct diagnosis. Valuable advice is also given in this chapter regarding the education of these children. Throughout the book the space devoted to treatment is scarcely sufficient, while in certain instances most vigorous methods are advocated.

Thus, in gonorrhœal vaginitis it is suggested that "the patient be anæsthetised, the vagina irrigated with 1 in 40 carbolic solution, after which Glycerini Acidi Carbolici, 1 in 10; finally the cervix and uterine cavity be well swabbed out with the same solution." By such means a sterile uterine cavity incurs considerable danger of infection.

Again, in obstinate cases of retro-flexion unassociated with prolapse, hysteropexy is advised. In supra vaginal elongation of the cervix, the view is taken that the elongation is due to a hypertrophy and new growth, rather than a stretching of the part as the result of traction. The author also maintains that usually complete reduction is not possible, and suggests as treatment that a portion of the cervix should be amputated.

The chapters on Salpingitis and Extra-uterine Fœtation are excellent, and on the latter subject there is much that is new, with definite rules as a guide to treatment. Most interesting is the view taken of that somewhat obscure disease Deciduoma Malignum. By systematic microscopical examination of all his cases the author has come to the conclusion that these cases are definitely sarcomatous and of a particularly malignant type.

While there is much in the book of interest, both to the student and the busy practitioner, still in our opinion it presents no manifest advantages over the more generally known text-books on the same subject.

ALSO RECEIVED.—Hospital (weekly), Clinical Journal (weekly), St. Mary's Hospital Gazette, St. George's Hospital Gazette, Medical Temperance Review, Therapist, Treatment, Owen's College Magazine, Journal of Physical Therapeutics.

Test Examinations.

CHRISTMAS, 1900.

BIOLOGY.

Maximum marks 50.

1.—40 marks.—J. B. Ball.

2.—35 marks.—A. H. Clough, T. R. Harvey, J. E. Scales.

5.—30 marks.—R. P. Lewis, A. L. Morgan, J. H. Robinson.

8.—27 marks.—L. H. Burner.

9.—25 marks.—W. H. S. Burney, V. Costobadie, E. White, L. D. Stamp.

13.—20 marks.—E. A. Collins, V. Ledger, F. Morres, S. W. Robinson.

17.—15 marks.—W. C. Dickey, A. W. Eyles, C. H. Bryan, W. Floyd, H. H. Moyle, T. Norman, M. R. Smith, H. F. Wight.

25.—10 marks.—W. W. Vaughan, S. M. Wells.

27.—5 marks.—R. B. Dawson, T. J. Green, G. F. Greening.

30.—2 marks.—I. Valerio.

CONJOINT AND DENTAL CLASSES.
CHEMISTRY AND PHYSICS.

DIVISION I.—L. H. Burner, 82; H. Croot, 76; R. P. Lewis, 74; H. W. Jones, 70; W. Reeve, 70; A. L. George, 68; A. R. Durant, 68.

DIVISION II.—W. S. Stevens, 65; A. W. Eyles, 64; N. B. Soper, 64; R. B. Dawson, 58; J. S. Francis, 58; T. Vernon, 56; E. Farrant, 54; A. Goodey, 54; J. H. Robinson, 54; A. Shepperd, 54; M. Leckie, 53; H. S. Chandler, 52; J. O. Musson, 52; I. R. Fearn, 50; S. K. Poole, 50; L. U. Ransford, 50.

The above have qualified for Schedules.

DIVISION III.—E. O. Stevens, 44; B. B. Metcalfe, 42; F. Morres, 42; H. V. Mitchell, 36.

DIVISION IV.—F. Barkshire, 28; A. H. Forbes, 26; A. C. Dickson, 16; L. D. Stamp, 12.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Scale of Fahrenheit's Thermometer.

SIR,—I should like to add a few words in corroboration of what I have already stated* as to the origin and meaning of Fahrenheit's scale. This is not a question of supposition, as many have made it, but one simply of history. There was, first of all, the instrument described in the *Philosophical Transactions* in a paper which I said was supposed to be written by Sir Isaac Newton. It was an oil thermometer, with a scale starting from freezing, and making the first fixed point above this the temperature of the body; and this he called by the round number 12. This determined the scale.

I now find in Brewster's *Life of Newton* an account of this paper, which is simply and without hesitation called Newton's. Sir David Brewster describes the instrument, as I have said, which makes the freezing point zero and the temperature of the blood 12, followed by the higher temperatures of the melting points of different substances.

I have also had given me a paper on thermometers written in the year 1884 by Mr. R. H. Scott, the late Secretary of the Meteorological Council. He therein says:

> Newton comes next on our list, and in the *Philosophical Transactions* for 1701 we find a paper certainly from his pen on the scales of thermometers, and in it he announces that his instrument filled with linseed oil is marked 12 at the temperature of a man's blood. This is the first notice we have of blood heat on the scale.

Then comes a new point of interest by the appearance of the name of the great Dutch physician in the question. Mr. Scott, when speaking of Fahrenheit, says that he gave up a scale he had been using by the advice of Boerhaave in favour of one which marked blood heat, but doubling this to twenty-four for the sake of convenience. "He afterwards divided these degrees into quarters, and this gave him 96 for blood heat, a reasonably close approximation to the true value of the armpit temperature of a healthy subject."

I stated in my paper that in the *Encyclopædia Britannica* it is said that Fahrenheit founded his scale on that of Newton. Since I wrote this I have had an interview with Dr. Mill, Librarian to the Royal Geographical Society, the writer of the article, and he informs me that from the researches he then made, this certainly was his conclusion—that Fahrenheit took Newton's scale as his standard.

To my mind it seems quite conclusive that the thermometer now in use was originated by Sir Isaac Newton, and that he took the temperature of the human body as the starting point of this scale.—I am, etc.,

SAMUEL WILKS.

Grosvenor Street, December 1st.

* GUY'S HOSPITAL GAZETTE, Nov. 10th, 1900, p. 511.

South African Memorial Fund.

(This Fund has for its object the erection of some permanent Memorial in the Hospital to those Guy's men who have fallen in South Africa.)

THIRD LIST OF SUBSCRIBERS.

	£	s.	d.
Amount already acknowledged	67	17	0
F. Newland-Pedley, F.R.C.S.	5	5	0
H. G. Howse, M.S.	2	2	0
W. Arbuthnot Lane, M.S.	2	2	0
W. C. C. Pakes	2	2	0
Prosectors	1	10	0
E. F. H. Hardenberg, M.B.	1	1	0
A. P. Beddard, M.D.	1	1	0
F. Durham, F.R.C.S.	1	1	0
P. F. Henry	1	1	0
R. G. Hicks	1	1	0
J. Lewin Payne	1	1	0
C. J. W. Pinching	1	1	0
R. J. Pye-Smith, F.R.C.S.	1	1	0
F. H. Shaw	1	1	0
Rev. L. B. Sladen, M.A.	1	1	0
F. J. Steward, M.S.	1	1	0
J. F. J. Sykes, D.Sc.	1	1	0
M....	0	10	6
H. Leader, M.B.	0	10	6
W. A. Maggs	0	10	6
R. W. Mayston, M.D.	0	10	6
C. D. Muspratt, M.D.	0	10	6
H. J. Spon	0	10	6
One of the Old Disguysed	0	10	0
J. M. Thorne	0	5	6
C. R. N.	0	5	0
E. J. F. H.	0	5	0
O. M.	0	5	0
H. M. Hardy	0	5	0
	£98	8	6

Guy's Hospital Clubs' Union.

We are requested to publish the following new regulation with regard to the cheap railway tickets to Honor Oak Park:—

> "Moreover, they shall not be used by students residing at or near Honor Oak Park for the purpose of travelling from Honor Oak Park to London Bridge and back."

Pass List.

University of London, December, 1900.

M.D. EXAMINATION.

A. H. Carter, E. Fisk, H. E. Hewitt.

J. A. Butler, J. T. Dunston, H. L. Eason.

Passim.

A Very Happy Christmas to Everybody—not only to those who form the active living part of Guy's at the present time, but also to those who, scattered far and wide over the globe, still retain, like true Guy's men, their affection and attachment to the old place, and continue to follow with interest its changes and progress. Christmas is a time of *réunion* all over the world, and may it be so also with Guy's and Guy's men, at least in spirit if not in the flesh.

Wherever we move we see and hear indications of the coming festivities. The lectures have ceased. The dissecting-room is empty and deserted except for a few well-belaboured remains. The approaches to the hospital are beset with the bearers of holly and evergreen. At every turn we are brought up suddenly face to face with formidable bundles of green floating in mid-air. We hear stories of Sisters taking journeys to Covent Garden at 4 o'clock in the morning to purchase the best produce of the country at the lowest prices. When we turn to the wards we find report-writing, blood counts and other forms of torture have given place to the more convivial occupations of wreath-making, ladder-climbing and afternoon tea. As we approach the dining hall of the college or the dresser's room, we hear the strains of chorus singing, the twang of the banjos, and the toot-tooing of the funniphones.

All this tells us that Guy's will not be backward in the Christmas merry making. To most of us Guy's is not only the centre of our work, it is also the centre of our interests and our pleasures, and so there is no lack of men who are willing to sacrifice their own personal and private obligations and to throw in their lot with the rest and celebrate the Christmas festivities by helping to make the place bright and merry for those within its walls. We can assure those who are doing this for the first time, that they will vote this Christmas one of the best they have ever spent.

There are no very startling novelties to announce—at least we have heard of none. Everything is to happen much in the same way as it has happened before. The Christmas Niggers will make their round of the wards on Christmas-Day in the time-honoured way. Judging from the men who have volunteered their services, and the zeal with which they have practised, we are sure they will be by no means inferior to their predecessors. We hope to print elsewhere a time-table of their proceedings. It is early days yet to speak of the decorations of the wards, but we have heard there will be a display of much originality of thought in the designs. The coloured electric lamps which were used last year to such effect in a few wards, thanks to the energy of Mr. Swan, are to be adopted almost universally. Every ward is to be provided with forty coloured lamps. This has been arranged at a mere nominal expense. The lamps used are the ordinary white lamps kept in stock. They are coloured by dipping in a coloured varnish employed for straw hats, and can be easily decolorised afterwards by methylated spirit, and used for ordinary purposes. The connections will be provided out of the scrap wire which has accumulated from the extensive electric work, which has been carried out of late.

On Boxing-Day will commence a series of concerts in the wards, when each ward will be seen at its best in its garb of green with its fascinating Sister, its "dear sweet babies" and its dainty tea. Many kind professional friends have volunteered their services, so that we may look forward to a week of great gaiety and amusement. We understand that there is to be no concert in Clinical wards, but the patients are to be regaled with the strains of music every afternoon in the Christmas week. We would impress upon our readers that the concerts are given primarily for the patients, and we trust therefore that any visitors will avoid their presence in any way obscuring the view of those who are compelled to keep to their beds. Elsewhere will be found the day and hour at which the various concerts will take place.

This is the last issue of the Gazette for the old year, and also for the century. It is with much regret that we have to announce that in the meantime the duties of editorship have fallen upon other shoulders. Mr. Stanley Hodgson, who has throughout this year conducted the Gazette so efficiently, and with such entire satisfaction to all, has joined an expedition to West Africa for six months. We witnessed his departure from Euston this week. We shall miss his genial personality from amongst us. We can only wish him "good luck," immunity from the evils of the mosquito bites, and a safe return to our midst. We hope to receive contributions from his pen from time to time, which we are sure will prove of interest to our readers. It is with considerable diffidence that we step into the shoes he has left behind, and we have little hope that they will fit the new feet so becomingly, still we shall do our best, and for the rest we must crave the forbearance of our readers.

We publish elsewhere a further subscription list of contributions to the "South African Memorial Fund," from which it will be seen that we have barely reached £100. We have received no further suggestions as to the substantial form which the memorial should assume. We would impress upon those interested that, whatever may be eventually decided upon, will only be done, after a complete consideration of the various suggestions by some thoroughly representative body. We disclaim any idea of taking upon ourselves the responsibility of choosing between the many alternatives presented. It is impossible, however, for the questo be seriously considered till we have some idea of the sum our fund is likely to reach. We feel sure that there are still many who are in sympathy with the object of the fund, and are willing to contribute according to their means, and we would urge them to send their subscriptions along as soon as possible, so that we may complete our list at an early date in the new year.

On Thursday, December 13th, the two new ante-chambers to the front surgery were opened to the public. They are in all respects masterpieces for convenience and cleanliness. Everything has been designed to help the dresser to carry out the principles of asepsis to the highest degree possible, and what is equally important, when there is good daylight outside it has a means of entrance into these rooms. Blessings are never quite unmixed, and it is so in this case; for with the multiplicity of rooms it often requires considerable patience and careful searching before one lights upon the A.H.S. of the front. When the H.P. comes into the surgery in response to a call, he first dodges in and out of the various compartments in quest of the "man in charge," but, as the "man in charge" is also dodging in and out, a game of "Box and Cox" may proceed for some time before they meet face to face. The next step in the proceedings then commences, namely, to find the patient. This is generally a simpler matter, but when the A.H.S. at one end points somewhat indifferently and says, "He is in the room over there," there being three rooms over there, the matter is not so simple as it might at first appear. It has been suggested that rooms be numbered or lettered for the purposes of description.

In the *Free Lance* for December 8th, appears an article under the heading "Charity at London Hospitals," and this article is worthy of the closest attention, insomuch as it exemplifies in the clearest possible fashion the decay of modern journalism. The *Free Lance* is young, very young indeed, and prone to all the errors of hot-blooded youth, but the editor of this paper is not young, nor can he be accused of inexperience in matters journalistic, and therefore he must be fully aware of the literary crime which has been committed under his patronage. He has allowed to appear, in the position of honour in his paper, a curiously hysterical attack on medical students in general, on their ways, fashions, customs and appearances as studied by one Helen Jerome. He has allowed this poor woman to pour out before the world (for Mr. Clement Scott need not be told that all the world reads the *Free Lance*), the wierd story of her distorted dreams; he has allowed her to voice her secret ravings and mutterings that all

may hear, and he has not even insisted upon a rigid adherence to the elementary rules of English grammar.

The ignorance of the rules of her art, the childish ignorance displayed by this woman is subject more for pity than rebuke. Her display of fallacies, illogical deductions and false premises, might stock a work on logic; these, in a woman-writer, can be forgiven. But her ignorance of her subject-matter which she strives to cloak under a flimsy garment of detailed particulars, is culpable in direct proportion as it is misleading. We would advise Helen Jerome to take a couple of months holiday, preferably in some quiet village where she can obtain perfect rest, then, on her return to London, we would strongly advise her to abstain entirely from the pursuit of letters. She has mistaken her vocation.

The cup so kindly presented by Mr. Clement Lucas eighteen months ago to the winners of a tug-of-war between the firms, has at last been triumphantly wrested from the "Lucasites" by the valiant firm of Mr. Jacobson. The tug took place in front of the "Nursery" and was witnessed from the adjacent windows by many of the fairer sex. It was a most exciting tussle. The Jacobson firm won the toss for the ground and carried off the first pull with ease. Then came a hard fight, in which the sinews of both firms were strained to the utmost, and which ultimately resulted in favour of the Lucas firm. The third pull decided the fate of the cup, and it may now be seen sitting majestically in Naaman ward. The "Lucasites" and the head of the firm himself are much too good sportsmen not to admit that it is far more satisfactory and interesting that the cup should change hands occasionally. The temporary defeat will be doubtless fully retrieved by a triumph of strength in the near future.

If one were to lend a sympathetic ear to the complaints one hears poured out upon all manners of things and conditions of things, one might fill many pages of the Gazette with them. Our steady progress at Guy's is perhaps in part due to this "healthy discontent" which pervades the place. There is one grievance, however, which seems worthy of consideration. It is the condition of the telephones. We are certainly a little behind the times in this respect. They are always going wrong! One has to consider, no doubt, that they are handled by many different people, and perhaps not always in too gentle a manner. But a further trouble is the constant interruption which one is liable to suffer from quarters other than those with which one believes oneself in communication. We have it on good authority that the matter is under serious consideration. No extensive improvements are being made at present, as it is proposed to introduce an entirely new American system with an automatic exchange as soon as further details of the system have been worked out. It is an extremely simple system, requiring only two wires from each point to a central automatic exchange. By this system one will be able to communicate from any one point to any other to the exclusion of any interruption from other points. Such a system would prove a great boon to a place like Guy's with its many departments, and we hope we may see it put into execution in the new year. We must have patience.

We notice in the *Lancet* that Mr. John J. Nason, M.B. Lond., M.R.C.S. Eng., on his resignation, after forty years' official connection with the Stratford-on-Avon Hospital as an honorary medical officer, is to be presented with a testimonial in recognition of his valuable services to the institution. He has consented to sit for his portrait, which is to be hung in the board-room, and he will be the recipient of an illuminated address, accompanied by a piece of plate.

Sir Claude MacDonald in his despatches relating to Pekin, warmly commends the devotion and skill displayed by Dr. Wordsworth Poole, C.M.G., in his attention to the sick and wounded during the siege of the Legations. We offer him our sincere congratulations.

Infective Endocarditis.

A paper read before the Physical Society on Saturday, December 8th, 1900, by Mr. Stanley Hodgson.

Mr. President and Gentlemen,—When, some months since, your secretary made known to me that it was your pleasure that I should read a paper before you, I must confess that after the pleasurable sensation evoked by his letter had retreated beyond the threshold of consciousness, a feeling akin to despair succeeded in its place, and this feeling has attended me even unto this day. When judged from the purely external standpoint, the mere writing of a paper on a subject which should be more or less familiar to the writer, should present little or no trouble and certainly no anxiety, but when the matter is put to the real test of practice the thousand and one obstacles that beset the path of the amateur monographist, begin to evince their presence in no undecided manner. In the first place, the choice of a subject was a question which gave me a lot of worry; as far as I was concerned no particular subject had any especial claims on my consideration. Fortunately I was helped out of the difficulty by suggestions from friends, and, acting on one of these suggestions, I gently divulged my secret to your secretary and committed myself to Infective Endocarditis. Then considerations of etiquette began to manifest themselves and I learned the ancient custom which demands a sacrifice of clinical reports on the altar of the God of Statistics. This opened up a fresh source of trouble and annoyance, and everyone who has had experience of reports, medical or surgical, will sympathise with me after my journey through many volumes of those terrible annals. Indeed, it is a matter for real sorrow that so many of our reports, through the slackness or untrammelled stupidity of the writers, fall from the high pinnacle of utility to which they had almost attained down to the level of mere cumberers of book-shelves. And after the store of home materials I was led to tap the resources of foreign institutions, under the soothing influence of a comfortably equipped library, and then for the first time I found some recompense for my trouble.

It is only natural that in an attempt to deal with any subject, however vast, that we should strive to define some limits beyond which the work would be irrelevant. In the case of infective endocarditis, the primary choice of a name is still a subject of controversy, and this is less a matter of wonderment when it is considered how the study of the disease has advanced since its first discovery. With each new point elucidated, a not unnatural attempt has been made to make the title of the disease more strictly connotative of the ascertained facts. According to Huchard the first description was that of a case of suppurative endocarditis by Andral in 1829. In the controversy that followed, the propriety of the term Suppurative was discussed and condemned by Rokitansky, only however to receive reinstatement at the hands of that master scientist, Virchow. Clifford Allbutt, however, gives Bouilland in the years 1824–32, as the first to mention acute endocarditis with pyæmic symptoms, and adds that Senhouse Kirkes was the first physician to realize the connection between the two factors. The latter part of this statement is confirmed by the independent evidence of Hanot, who goes further and attributes the whole credit of the discovery to the same Senhouse Kirkes. However, the disease soon came under discussion and received many names, each for the time being, excellent, but each allowing a loophole for attack and adverse criticism. Although the majority of titles introduce the clinical feature of endocarditis with a qualification, yet there is one which is very suggestive of the disease and does not render incompatible those known cases where the endocardial mischief is only ascertained after death. I refer to Sir Samuel Wilks' title of Arterial Pyæmia, which was suggested in 1870. Possibly nowadays, the best nomenclature is that which owes its origin to the discovery of bacteria, and by using the title Infective Endocarditis, the objections which are felt to hold against the other names, become non-existent. Infective endocarditis is not necessarily malignant, nor ulcerative, and on the other hand ulcerative, including atheromatous changes in this title, is not necessarily infective; but infective endocarditis implies absolutely the existence of bacteria and so justifies its use.

The definition of the disease is by no means easy. Casually everyone has a mental picture which is suggested by the term Infective Endocarditis, and this picture is in all probability the vision of a real succession of symptoms which made at the time a deep impression on the observer. It is only when the attempt is made to speak absolutely that the difficulty arises. Here bacteriology does not help us, for there is no specific organism of the disease. Smith, of the London Hospital, requires that there shall be on post-mortem examination of the cardiac valves "Swelling, loss of epithelium, vegetations with loss of tissue and naked-eye ulceration, and that a bacteriological examination of the deposit shall show the presence of pathogenic organisms." If the valves are sterile he cannot reconcile the case with his definition. On the other hand, Gibson, quoting Hanot, says, "Whether in respect of the special nature of the microbe, of difference in the intensity of its action, of varying power of resistance, there may be two modes of development. In the one, the lesions in endocarditis consist of changes with a tendency to localize and concentrate themselves to resemble more and more the fibrous tissue of a scar, and in this way to a certain degree to lose infectious characters. Such is attenuated infectious endocarditis, or benign endocarditis of the physician, which allows the individual to pass from an acute to a chronic condition. On the other hand, the endocardial lesion may preserve in a high degree the original infectious character, when the morbid tissue has a tendency to break down and be resolved into particles which assist in transporting the infectious agent and

penetrating deeply into the organism. Such is malignant endocarditis, infectious and infecting, brought first into prominence by Senhouse Kirkes. Such a statement as this at once precludes the possibility of classifying under the head of infective endocarditis any case which is not brought to a fatal issue. The tendency, however, at present is not to attach such a hopeless prognosis to every case of this nature, and although the correct diagnosis of infective endocarditis makes the future extremely grave, yet a subsequent recovery does not lead physicians to doubt the accuracy of their observations. Kelnyak prefers the simpler statement that it is "a process resulting from the invasion of the endocardium by micro-organisms, and characterised by proliferative, destructive or suppurative changes," while Allbutt, reverting to the bolder bacteriological view—"in both forms of acute endocarditis, micro-organisms are found, and though in some cases the same organisms have been found in the two forms, yet as the malignant very frequently implants itself on the benign, and produces new and fatal symptoms, it is desirable to consider the two differently." So with a recognition that infective endocarditis includes a bacteriological invasion of the patient, with foci on the valves, with toxic and valvular symptoms, either or both, and a frequency to metastasis and embolism, the exact determination of a definition may be left unsolved.

Accepting, then, the now undisputed view that micro-organisms lie at the bottom of the mischief, it now remains to be seen whether there is any predisposing cause for the bacterial attack on the valves. The only help to be obtained in this matter, is that afforded by the study of statistics. In the Manchester Royal Infirmary, of 65 cases examined, 34 per cent. gave a clear history of rheumatism, and 77 per cent. a history or evidence of pre-existing valvular lesion. Osler's collection of 209 cases includes three-quarters of that number with evidence of old valvular lesion. In Goodhart's cases, 61 out of 69, and in Washbourn's, 59 out of 100 were noted as having pre-existing valve disease. Of 48 cases at Guy's between the years 1888 and 1893, 21 showed a history of rheumatism, and 2 a history of valvular lesion, while scarlet fever, pneumonia, typhoid fever, chorea and influenza, were antecedents in 6, 5, 3, 2 and 1 cases respectively. From these figures there can be little doubt that a valvular lesion pre-existing, forms a favourable nidus for the growth of bacteria. It has also been shown by an analysis of cases, that abnormalities in valvular detail are predisposing to infective endocarditis; this would follow as a natural corollary of Rokitansty's theorem, that congenital malformations predispose to fœtal endocarditis. There is one factor which, so far, has not been determined in the consideration of these cases, and no doubt considerations of physical labour will contend against any such determination. Before accepting the dictum that rheumatism or heart disease, using the terms as loose synonyms, is a precursor of infective endocarditis, we ought to have the proportion of heart lesions found in all patients admitted to the medical wards, relative to the total number admitted. Then only could we say that old heart disease was found in a greater proportion of cases of infective endocarditis than in other diseases.

It is in this connection that Foulerton, of Middlesex Hospital, denies that the incidence of infective endocarditis is markedly favoured by a pre-existing simple endocarditis, for of 504 cases of simple endocarditis analysed, 260 were males and 244 females, that is 51·5 per cent. males, 48·5 per cent. females; while of 70 cases of infective endocarditis, 54 were males and 16 females, that is 77·1 per cent. males, 22·9 per cent. females.

If, then, the old heart lesion bore an important part in the origin of infective endocarditis, why this discrepancy in percentages? It must be admitted at once that this variation in susceptibility in the sexes, is not a mere caprice in one set of figures.

In the 65 Manchester cases, the percentage is males 70·7, females 29·3. In 84 cases analysed by Kanthack, 60·7 per cent. were males, 39·3 per cent. females; and in the 48 cases at this hospital to which I have referred, the percentages are respectively, 64·6 males, 35·4 females. I have so far been unable to find any explanation or suggested explanation of this curious ætiological fact.

Admitting, then, despite Foulerton's objections, that an old valvular lesion plays a not unimportant part in the production of infective endocarditis, it is interesting here to examine briefly into the causes of simple endocarditis, for by so doing it may be shown that Allbutt's statement with reference to the same bacterium producing the so-called simple and malignant endocarditis is literally true. The casual relation between rheumatism and endocarditis requires no demonstration; Osler, however, states that endocarditis is not uncommon in scarlet fever, is common in pneumonia (his figures gives 5 cases in 100), and by no means rare in phthisis (12 in 216). In chorea he found endocarditis in 62 out of 73 fatal cases. It is, however, generally accepted that it is rare for a simple endocarditis of rheumatism to develop into the malignant form, and in the 209 cases which he collected he found only 24 which adopted this course. In the 48 cases above-mentioned I find only 4 in which rheumatism passed directly on to infective endocarditis, and if this disease is rare in rheumatism it is still more less frequent as a direct sequela of chorea. What must be accepted as the most frequently found acute disease complicated with the severe form of endocarditis is undoubtedly pneumonia, for in Osler's 209 cases 54 owed their onset to pneumococcal deposits in the lungs, while in the 23 cases investigated in Montreal no less than 11 were directly traceable to lobar pneumonia, and of the Manchester cases 12 out of 65 developed from acute pneumonia. And it is also to be noticed that the endocarditis in pneumonia is always of a particularly malignant type, with a great tendency to meningeal complication, a fact which is somewhat difficult to understand when the toxicity of the micrococcus is considered in pneumonia. Indeed, the nature and scope of

the pneumococcus is somewhat obscured when observed only in relation to lung disease.

Garrod quotes a case in which a patient without history of rheumatism suffering from middle ear disease developed pneumonia, and evinced auscultatory signs of mitral and aortic disease and died. It was then found that he had congenitally deficient aortic valves which were covered with recent vegetations and showed ulcerations. He had pathological evidence of left lobar pneumonia, with, in addition, small breaking down infarcts in the tissue. Infarcts were evident in the spleen and kidneys, and a hæmorrhage on the parietal lobe of the brain, beneath the pia mater was also recorded. Bacteriological examination of his heart's blood showed a mixed infection of pneumo- and streptococci and the bacillus coli communis. The pus from the middle ear also gave colonies of these bacteria with staphylococcus pyogenes aureus; in addition the spleen gave pure cultures of bacillus coli communis.

Garrod considered this case to be mixed pneumococcal infective endocarditis secondary to pneumococcus (mixed) in otitis media, with pneumonia as a secondary lesion to the pneumococcal endocarditis. Again, Anderson quotes a case which came under his observation in which a sailor, free from rheumatic history, but with a family tendency to heart trouble, whatever value that may be, became suddenly ill after a heavy supper, with rigors, intense colicky abdominal pain, vomiting and diarrhœa. With a succession of rigors, with repeated sweats and attacks of vomiting, the disease ran a rapid course, and the patient died after a total illness of thirteen days. During life, culture tubes were inoculated with patient's blood, but remained sterile. At the necropsy the vermiform appendix was found to contain a small quantity of muco-purulent material, with a small necrotic focus. There was no foreign body in the appendix. The spleen was large and contained numerous infarctions. The portal vein showed ante-mortem thrombosis, there was fluid in the pleuritic and pericardial spaces, and on section the heart showed recent vegetations on the aortic valves, with perforation of one segment, the sinus behind being almost filled with vegetations. The mitral valves showed old fibrosis, but no recent vegetations. Cultures from the peritoneal sac, from the right auricle and the spleen, remained sterile. But a culture from the aortic valves gave a pure growth of pneumococci. The lungs were quite free from pneumonic changes, so that the source of infection, *defaut de mieux*, lay in the appendix. Unfortunately the appendix was never examined bacteriologically, for the necropsy was performed in a private house, and the writer quaintly states that the appendix "got lost." That such a source of infection is possible, is evident from the researches of Flexner, who found a virulent form of pneumococcus in the mouths of 20 per cent. of healthy individuals examined. As the micrococcus is peculiarly sensitive to acid media, infection through the gastro-intestinal tract is prevented by the acid stomach-contents. In this case, however, the patient had an enormous meal, and probably by his indiscretion in choice of viands, inhibited his natural bacteriological powers sufficiently to allow the pneumococcus to gain a foothold in his intestine. Another case in the same category, but without evident source of infection, is that of a man whose history is recorded by Lafleur. This patient had a history of malaria and gonorrhœa; but never rheumatism nor syphilis. He was admitted with a doubtful attack of subacute rheumatism. The illness pursued a general septic course, and the patient gradually sank. Five days after admission a blowing systolic murmur was discovered at his heart's apex, with a very faint diastolic bruit in the same area. The sputum showed neither tubercle nor pneumococci, the blood gave no growths, but at the autopsy there was acute ulceration of the mitral valve, with pneumococci in numbers on the vegetations. It will be noticed in this case that an examination of the blood by bacteriological processes gave negative results. This is the conclusion of a great number of competent authorities, but on the other hand, two American experimenters, James and Tuttle, succeeded in getting, ante-mortem, cultures from the blood of patients suffering from infective endocarditis in four out of five cases, when the organism was the pneumococcus.

The method they adopted was strictly practical, and as far as can be judged without actual experience, suitable for use by hands not specially trained to the niceties of bacteriological research. An ordinary hypodermic needle was fitted on a glass cylinder by careful grinding of the end of the tube. A plug of cotton wool closed the other end of the tube. The whole was contained in a large test tube, also plugged with wool, and sterilized in an ordinary dry air sterilizer. This, with a pair of sterilized forceps and the usual media in tubes (not plates) completed the outfit. The patient's arm was well washed with soap and water, compressed with Hyd. Perchlor., and after the lapse of a few hours again washed with sterile swabs soaked in sterile water. The median basilic or cephalic vein, or one of the veins of the forearm was then rendered prominent by a suitable tourniquet and the needle plunged boldly into the distended vein. Blood flowed up the tube to a slight extent and 15 to 20 cc. were obtained by the simple expedient of sucking at the cotton wool closed end. Tubes were inoculated immediately with the blood in the usual manner. The sterile forceps were employed, if necessary, to remove the needle or to readjust it in the tube. This piece of apparatus is cheap, and in the hands of its inventor very successful.

Bullock, of London Hospital, and Pakes, of this hospital, have not succeeded in obtaining cultures from the living blood of patients with infective endocard itis In the case of septicæmia, however, Pakes obtained growths of streptococci on no less than sixteen different occasions, so that the objection that the blood is drawn antiseptically and not aseptically cannot hold in the case of this observer. Abrahams, of Westminster Hospital, apparently finds no difficulty in obtaining cultures from patients with infective endocarditis, for in eleven

cases examined he obtained streptococci in five, staphylococci in three, and these two cocci mixed in one case. At the same time, he asserts that he has found similar organisms in several cases of pure rheumatic endocarditis, so that his experiments are open to the obvious criticism that the bacteria were obtained from the surface of the patient or elsewhere, other than his anatomical interior. It is worthy of mention that the two cases in which he did not obtain cultures were each secondary to an empyema following pneumonia.

I fear that I may have given the impression that the pneumococcus is almost entirely responsible for endocarditis infectiva. This, I need hardly say, is not the case; the majority of cases occurring are probably due to the streptococcus or to one of the staphylococci. Pneumococcus, however, plays a very considerable part in the disease, and is by no means the rare causative agent that is sometimes imagined. Statistics in this country are somewhat liable to lead to erroneous ideas on this point, owing to the difficulty which is still experienced in obtaining access to suspected parts before the morbid anatomist has ruined the experiment with his dirty knife and fingers. As Pakes says (Pathological Section of British Medical Association, 1899), "there are still morbid anatomists who are totally unaware of the difficulties attending bacteriological research and who make no endeavour to remove the valves for bacteriological examination under aseptic conditions, and this even when the case has been rightly diagnosed in life." In the Johns Hopkins Hospital the bacteriological examinations are very thorough, and, as a matter of routine, every heart which is suspected to be the seat of bacterial invasion is opened aseptically and examined for micro-organisms. For the benefit of those who are not conversant with the methods of obtaining material of value for bacteriological examination I would mention Bryant's contribution to the B. M. A. meeting of 1899, reported in the Journal of the Association.

The following is a list of the organisms which have been found on the valves or endocardium in cases of infective endocarditis:—

Streptococcus pyogenes.
Staphylococcus pyogenes aureus and albus.
Bacillus coli communis.
Bacillus pyogenes frelidus.
This bacillus is, according to Pakes, identical with the bacillus coli communis.
Diplococcus pneumoniæ (Fraenkel).
Friedlander's bacillus.
Bacillus of tubercle.
Bacillus typhosus.
Bacillus of diphtheria.
Bacillus of influenza.
Gonococcus.

And to these must be added the following rare species which have so far only been found in isolated cases of infective endocarditis and are not known to be associated with any other process of infection:—

Bacillus endocarditis gusius.
Micrococcus endocarditis rugatus.
Micrococcus zymogenes.
Bacillus endocarditis capsulatus.
Bacillus immobilis et fœtidus.

I attempted to obtain specimens of these rare bacteria from Krahl, of Prague, Bohemia, to show you to-night, but even this universal provider had to confess that his laboratory did not contain these species.

Von Jürgensen, with a tacit acknowledgment of the discovery of a syphilis micro-organism, adds this individual to the list. But his premise is by no means universally allowed, so the inclusion of the organism as a factor in infective endocarditis must be, for the present at least, waived. Practically, the bacteria found are in much less variety. Twenty cases of Kanthack's showed:—

7 pneumococci, of which 4 were mixed with staphylococcus or streptococcus, and 3 were pure.
7 streptococci—5 pure.
5 staphylococci—2 pure.
"Micrococci"—twice.
"Diplococci"—once.
Typhoid bacillus—(mixed) once, and
Tubercle—once.

Pakes examined 28 cases, and obtained satisfactory results in 21. Those analysed show:—

13 streptococci (pure).
1 streptococci and staphylococci.
1 streptococci and bacillus coli communis.
2 staphylococci.
1 pneumococcus.
1 gonococcus.
1 bacillus pyocyaneus.
And 1 case, although apparently infective endocarditis, would give nothing either bacteriologically or microscopically.

Pakes is of opinion, in reference to the large number of streptococcal infections, and the curious fact that, whereas in streptococcal septicæmia the micrococcus may be obtained from the living blood, while in streptococcal endocarditis the opposite holds good, that the infection in the latter disease is considerably less virulent, and although septicæmic symptoms may set in, these are due rather to the lowering of the patient's natural resistance beneath the level of the specific virulence, than to the specific virulence being initially greater than the patient's natural and ordinary degree of immunity. These statements are beautifully expressed in a graphical manner in the curves of relative immunity drawn by the same author. Here, perhaps, I may mention the fact, that in one of the 48 cases analysed by me, there is a report of the discovery of streptococcus in the blood of the patient during life by Washbourn.

After a consideration of the casual agents in the disease, the next investigation must be directed to a study of the means of ingress of the organism. I have already mentioned two, viz., otitis media and typhlitis. Washbourn's cases give the following causes in thirty cases where the mode of entrance was clear.

Pneumonia	5
Pneumonia and empyema ...	1
Empyema alone	1
Phthisis	3
Gonorrhœa	1
Septic trouble (various) ...	18, including—

Suppurating fibroid of uterus 1, sloughing dermoid of uterus 1, sloughing retained placenta 1, amputation of cervix uteri 1, femoral thrombosis after abortion 1, urethral stricture 1, prostatic abscess 1, traumatic meningitis 1, suppurating hip-joint 1, periostitis 2, necrosis of rib 1, necrosis of bone (traumatic) 1, glossitis 1, parotitis 1, cellutitis (traumatic) 1, and ulcerating malignant growth 1.

Graham Steel's collection of cases show infective endocarditis secondary to pyæmia, erysipelas, pneumonia, typhoid fever, diphtheria, scarlet fever, influenza, dysentery, malaria, empyema, local purulent peritonitis, otitis media, suppurative meningitis, and suppurative cholecystitis,

For some reason which is rather difficult to prove infective endocarditis is said to be more common in August than in other months. There is absolutely no foundation for this statement. Even the small number of cases examined by me for the purposes of this paper show individuals in every month, and by the chart which I have appended it will be readily seen that there is no obvious season for the disease. With age, the question is entirely different, and my chart showing the curve obtained by putting the number of cases per unit of five years gives a very striking demonstration of the dictum that infective endocarditis is a disease, not of the young, nor of the old, but of the prime.

At the beginning of this paper I warned you that statistics were inseparably bound up with the question of infective endocardits. I must tax your patience with one more set of figures, and then my arithmetical labours will be finished. It is an undoubted fact that whereas in infective endocarditis the left side of the heart is infected considerably more frequently than the right, yet the proportion of right-sided to left-sided infection in this disease is much greater than in simple or benign endocarditis. Osler's 209 cases show :—

Aortic and mitral	41
Aortic	53
Mitral	77
Tricuspid	19
Pulmonary	15

And in 9 the right side alone infected.

The 65 Manchester cases show :—

Mitral and aortic	20
Aortic alone	18
Mitral alone	17
Pulmonary	1
Tricuspid and mitral	2
Tricuspid, mitral and aortic	2
Right and left sides	5
Right side only...	1

The 48 Guy's cases show :—

Analysis of Lesions.

No. of cases		48
Deaths		37
Inspections		34
Infarcts in 21.		
Total number with	Aortic lesion	20
	Mitral lesion	19
	Tricuspid lesion	3
	Pulmonary lesion...	2
	Mitral and aortic lesion	9
	Aortic and tricuspid lesion ...	2
	Aortic and pulmonary lesion ...	1
	Tricuspid and pulmonary lesion	1
Number with	Aortic lesion alone	8
	Mitral lesion alone	10
	Tricuspid lesion alone	0
	Pulmonary lesion alone	0

One case, quoted by James of New York, of an intensely acute infective endocarditis of staphylococcal origin, was supposed to get its origin from septic absorption due to the patient immersing his arm to the shoulder in a blocked and filthy water-closet.

The explanation of the greater relative proportion of right-sided to left in infective than benign endocarditis, is explained by the supposition that the infecting material is conveyed to the right side of the heart by means of the venous system where septic thrombi are most common. The lungs receiving the material from the right ventricle, act as a filter and block the passage of infection to the left side of the heart. This would form a plausible explanation of the curious fact quoted by Bryant, that the lesion in gonococcal endocarditis is nearly always in the right heart.

The clinical features of infective endocarditis are too well known to need much reference. A critical survey of cases bears out Cleveland's statement that early infective endocarditis, before emboli, etc., render diagnosis certain, is characterised by high temperature, soft dicrotic pulse, almost describable as modified aortic, and *intense anæmia*. The temperature may be septic in type, *i.e.*, high nocturnally, and low again the next morning, or it may be of the continued or typhoid type. It is held by James that the former is typical of streptococci and staphylococci, and the latter of pneumococci. Be this as it may, it is a recognised fact embolic disasters are less frequent with this latter microbe than the former, and the explanation of this statement is said to lie in the curious smoothness which characterises pneumococcal vegetations.

Generally, hæmorrhages, whether retinal, intestinal or subcutaneous, are common in infective endocarditis, and are directly traceable to detatched vegetations. Headache, sickness and diarrhœa crop up in the reports with automatic regularity, and whenever an enthusiastic clerk has estimated the erythroblasts and leucocytes he finds marked anæmia and slight leucocytosis. A rapidly-changing bruit is singularly absent; in the majority, the

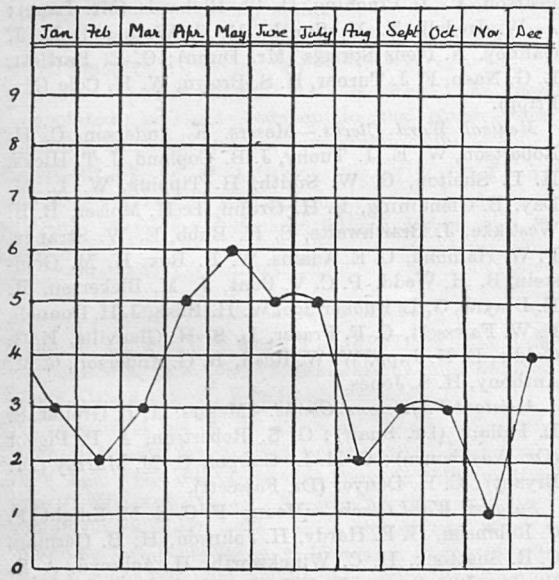
great majority, of the cases, the clerk reports no change in the heart-sounds from day to day, and week to week, and indeed, as Phear admits, the cardiac symptoms frequently occupy an inconspicuous place in the clinical history of these cases, and not rarely signs of cardiac disease may be entirely wanting. Also, progressive endocarditis, as judged by changing murmurs, is not necessarily malignant or infective, and those cases where an intense and sudden change in character is noticed are generally perfectly obvious from other clinical evidence.

The musical nature of the bruit is also of little value in the matter of diagnosis. Howship Dickinson quotes four cases of "musical" bruits described as—

(1) apical systolic, with musical tone;
(2) murmur like the squeak of a mouse;
(3) systolic whistle;
(4) squeak of a fiddle,

CHART OF FREQUENCY OF OCCURRENCE OF INFECTIVE ENDOCARDITIS PER MONTH.

Abscissæ = No. of Cases. Ordinates = Months

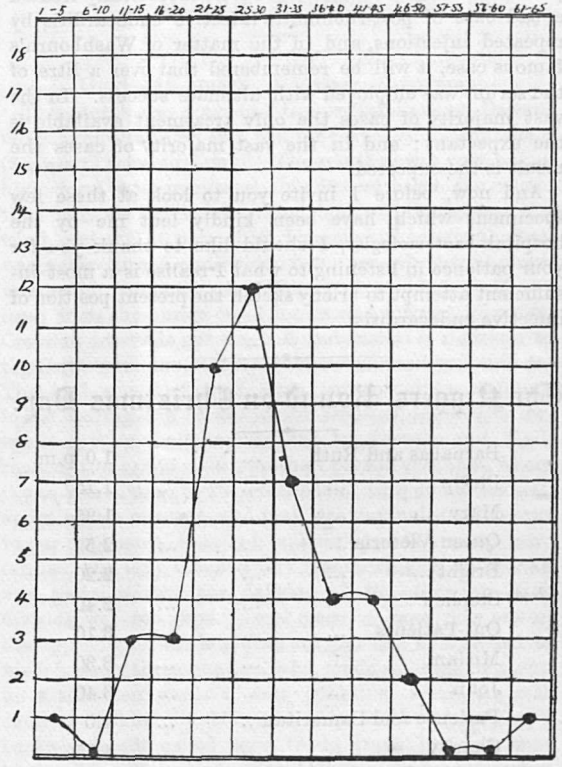


where there was an intense aortic lesion with inconsiderable mitral disease. The "musical" nature of the bruit was in these cases due to over-distension of the left ventricle during systolic contraction, and not to infective endocarditis. The duration of the disease is as variable as its bacteriology. Four days to eighteen months may be taken as broad limits, and the diagnosis may lie between malignant small-pox and tuberculosis. The diagnosis must be a matter for the moment; very often a process of exclusion may leave the field free, or a succession of typical symptoms may throw light on a dark case. One case of Kinnicutt's primary infective endocarditis, of staphylococcal origin, where the cardiac signs were only such as might readily be produced by muscular incompetence and relative insufficiency, and where the temperature was hyperpyrexial, the following were accepted diagnoses, each in turn disproved, until, before the end, the right diagnosis was reached:—

Typhus.
Typhoid.
Small pox.
Abnormal typhoid.
Cerebro-spinal meningitis.
Infective endocarditis.

CHART OF FREQUENCY OF OCCURRENCE PER PERIOD OF FIVE YEARS.

Age (in five year periods).



A keen eye for slight evidences of detached vegetations, a synthetic mind and a readiness to admit the error of previous diagnosis, seem to be requisites in the identification of doubtful cases of this disease.

As to treatment, there is only one word to be said. Try the antitoxin treatment early and continuously. Try the antistreptococcin first if there be no definite reason for doubting the presence of streptococci, and be prepared to vary your injections in order to meet the requirements of a mixed infection. If we bear in mind

that in a hundred cases of pneumococcal invasion there are—

66 per cent. Lobar pneumonia.
17 „ Lobular.
11·5 „ Meningitis.
10 „ Otitis media.
8·5 „ Empyema.
5·7 „ Infective endocarditis.

We shall by a mental comparison of the comparative frequency, of empyema and endocarditis, be able to check our diagnosis, and thus our serum treatment.

But in the serum treatment, there must be no half measures. Pye-Smith attempted this treatment and failed because the patient refused more than eight injections of 20 c.c.

Pollock gave two injections of 10 cc. each of anti-streptococcin, but, apparently to his surprise, lost his patient. Margaret Pearse, however, successfully treated a bad case of post-rheumatic infective endocarditis by repeated injections, and in the matter of Washbourn's famous case, it will be remembered that over a litre of the serum was employed with ultimate success. In the vast majority of cases the only treatment available is the expectant; and in the vast majority of cases the result is the expected.

And now, before I invite you to look at these few specimens which have been kindly lent me by the hospital bacteriologist, I should like to thank you for your patience in listening to what I realise is a most insufficient attempt to briefly sketch the present position of infective endocarditis.

The Niggers' Round on Christmas Day.

Barnabas and Ruth	1.0 p.m.
Philip	1.15
Mary	1.35
Queen Victoria	2.5
Bright	2.20
Stephen	2.40
Out-Patients	3.10
Miriam	3.30
John	3.40
Patience and Samaritan	4.0
Charity	4.15
Dorcas	4.30
Luke	4.45
Naaman	5.0
Job	5.20
Lazarus	5.35
Martha	5.50
Lydia	6.10
Cornelius	6.25
Astley Cooper	6.40

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants.—Messrs. J. A. Butler, F. Curtis, P. T. Manson, F. G. Gibson, N. F. Ticehurst, H. S. French.

Clinical Assistants in Medical Out-Patients.—Messrs. E. G. Wales (Dr. Shaw); C. Tessier (Dr. Washbourn); H. W. Brown (Dr. Bryant); E. Stott (Dr. Fawcett).

Obstetric Dressers.—Messrs. G. Evans, H. K. Lacey, R. C. Lawry, G. Clarke (January 1st); H. C. Keates, P. S. Mandy, J. Evans, A. H. E. Wall (February 16th).

Dressers in the Throat Department.—Messrs. J. D. Bridger, J. A. B. Hammond, A. W. Gator, J. A. Wood, H. Davies-Colley, G. S. Simpson.

Clerks in the Throat Department.—Messrs. R. P. Marshall, D. W. Smith.

Assistant Surgeons' Dressers.—Messrs. G. T. Wrench, G. W. C. Hollist, S. L. Prall, O. B. Travers, R. H. Terry (Mr. Symonds); E. Faulks, H. T. Palmer, J. D. Pearson, C. J. Pinching, O. W. Richards (Mr. Lane); A. W. Iredell, T. M. Smith, M. C. Wetherell, E. J. Gaffney, N. Ivens Spriggs (Mr. Dunn); C. E. Bartlett, L. G. Nash, F. J. Turner, H. S. Brown, W. H. Cole (Mr. Fripp).

Medical Ward Clerks.—Messrs. K. Anderson, C. H. Robertson, W. E. J. Tuohy, J. B. Copland, J. T. Hicks, H. L. Shelton, G. W. Smith, H. Tipping, W. L. M. Day, B. Glendining, E. H. Griffin, L. H. Moiser, B. B. Westlake, J. Braithwaite, C. H. Bubb, E. W. Strange, P. W. Hamond, C. E. Adams, W. F. Box, H. M. Goldstein, B. H. Wedd, P. C. V. Bent, J. M. Bickerton, R. E. Brayne, G. L. Buckeridge, W. H. Bush, J. H. Donnell, F. W. Fawssett, C. F. Fraser, L. S. H. Glanville, E. G. Goldie, E. N. Jupp, W. W. Read, R. G. Anderson, C. M. Anthony, H. S. Jones.

Assistant Physicians' Clerks.—Messrs. H. R. Grellet, S. L. Pallant (Dr. Shaw); G. S. Robertson, A. P. Piggot (Dr. Washbourn); C. M. L. Cowper, C. M. Murray (Dr. Bryant); C. H. Denyer (Dr. Fawcett).

Surgical Ward Clerks.—Messrs. F. C. R. M. Knight, F. C. Robinson, G. F. Hardy, H. Johnson, H. B. German, C. R. Shattock, H. C. Winckworth, H. Ackroyd, A. R. Brailey, J. S. Cooper, T. C. Lucas, D. R. Pike, J. Goss.

Clerks in the Skin Department.—Messrs. S. J. Ormond, F. W. Smith.

Dental Surgeons' Dressers.—Messrs. G. T. Collins (January-February); D. L. Morgan (February-March); M. J. Rees (March-April).

Pathological Assistants to Surgical Registrar.—Messrs. H. S. French, G. S. Simpson.

DENTAL APPOINTMENTS.

The following appointments have been made by the House Committee upon the recommendation of the Dental Council:—

Dental House Surgeons (for six months, from January 1st, 1901).—Messrs. S. C. Bowle, E. W. Corfe.

Assistant Dental House Surgeons (for three months, from the same date).—Messrs. E. L. Davis, W. E. Griffin.

Demonstrators in the Conservation Room (for six months, from the same date).—Messrs. J. B. Barron, A. C. Stroud, E. Phillips.

Assistant Demonstrators of Practical Dental Metallurgy.—Messrs. C. Mills, H. L. Whitlow.

Appointments.

CIVIL.

BURGHARD, FREDERIC F., M.S., F.R.C.S., has been appointed Surgeon to In-Patients at the Paddington Green Children's Hospital, London, W.

BYFORD, W. F., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of Health for the Borough of Ruthin, *vice* D. Jones, resigned.

ENSOR, C. A., L.R.C.P. Lond., M.R.C.S., has been appointed District and Workhouse Medical Officer, Tisbury Union, *vice* J. A. Ensor, deceased.

MCGAVIN, LAWRIE HUGH, F.R.C.S. Eng., has been appointed Assistant Surgeon to the North-West London Hospital, Kentish Town Road, N.W.

STURGES-JONES, W. E., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Medical Officer to the London and Pacific Petroleum Company, Talara, Payta, Peru, S. America.

NAVAL AND MILITARY.

WARD, J. A., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Medical Officer to the Training Ship, *Shaftesbury*, Grays, *vice* W. Robertson, resigned.

Lieutenant-Colonel J. S. WILKINS, D.S.O., Bombay Establishment, is promoted to be Colonel, from October 2nd. He was appointed Surgeon, March 31st, 1874, and became Brigade-Surgeon Lieutenant-Colonel August 16th, 1897. He was in the Afghan War in 1880, including the march to Kandahar under General Phayne (medal), and in the Burmese Campaign in 1886–7 (mentioned in despatches, medal with two clasps).

Nursing News.

MATRON'S OFFICE.

The Probationers' Examination on Nursing Subjects was held on Thursday, December 13th. The following is the list of successful candidates:—Probationers A. Allen, Anderson, Anderton, Armstrong, Beardsley, Blasson, Bodley, Boodle, Byrne, Carter, Chittock, Collie, A. Collins, Cook, A. Cope, E. B. Cope, F. Cooper, Cotterell, Crampton, E. Crowe, M. Davis, Dann, J. Dickson, Dingwall, M. Dixon, Earp, Elliot, Eldridge, G. Field, Gill, Guthrie, Hamlin, Hecks, Hills, Hopkins, Horsepool, E. C. Hughes, Hutton, Iszard, Jenkins, Layng, Lee, Leslie, Lightfoot, Maddison, McCalmont, Millidge, Milman, Morrall, Neale, Norman, Perriam, Pettit, Pickles, Purse, Ripley, A. Rogers, Ross, Russell, Salway, Savill, Savage, Sheldon, E. Simpson, Sister Katherine Maud, R. Thompson, Towsey, Tweddie, Walker, Ward, Watson, Webb, Wheatley, Wilkinson, Windemer, Wise, Witchell, A. Wood, L. Wood, Worthington.

Sport.

Rugby Football.

GUY'S v. CROYDON.

(GUY'S, 16 POINTS; CROYDON, 3 POINTS).

This match was played at Honor Oak Park on December 8th, and resulted in a win for Guy's by 16 points to 3 (2 goals, 2 tries to 1 try). The weather was very bad, a high wind and continual drizzle prevailed the whole time. Guy's lost the toss and had to play against the wind, and at 3.20 p.m., T. P. Thomas kicked-off; the ball was well returned and fielded by Orpen, who found touch mid-way between Croydon's twenty-five and the half-way line; from the throw-out a scrum was formed, in which Croydon forwards got the ball and rushed it right up to the Guy's goal-line, where it was kicked dead by Louisson. The ball was kicked-off from twenty-five, and touch found, during the scrum which resulted, the Guy's forwards got the ball, and headed by Thomas and Wall, rushed it in grand style over the Croydon goal line, where it was kicked dead by their full-back. Croydon kicked-off, and a scrum resulted, and play was gradually taken over to our opponents' twenty-five, here several scrums were formed, and Guy's looked very like scoring on more than one occasion, but the defence of the Croydon back division was too good. In a piece of loose play one of the opposing forwards picked up the ball and passed to his left wing three-quarter, who made an excellent run to within ten yards of our goal-line, where he was smartly tackled by Morgan. Up till now the Guy's backs were not called upon to do much, but now they began offensive tactics. The ball was gradually worked to mid-field by a series of scrums, from one of these the ball was smartly passed out by Wetherell, and, passing through the whole back division, reached McEvedy, who made a capital run, and, by dodging the full-back, scored in a favourable position, but the kick failed. Croydon kicked-off, one of their forwards being off-side, a scrum was formed, the ball was well heeled-out and passed to O'Brien, who attempted to drop a goal; the kick failed, and the ball was fielded by the full-back, who was tackled with it by Thomson on the Croydon goal-line, here a scrum was formed, and the opposing half-back got

the ball and passed out to one of the Croydon three-quarters, who got away, but Morgan, who was playing a magnificent game, tackled him on half-way line, and a scrum was formed here; the opposing forwards getting the ball between them rushed it right up to the Guy's goal-line. Some good defensive work was put in by Guy's forwards, Mum[illegible]s, Wall and Lawry being very conspicuous. The ball was gradually forced over our line, where it was kicked dead. Guy's then dropped out, and Milsom, following up well, charged down the return, and a scrum followed during which one of the opposing three-quarters got the ball, and was just beginning to look dangerous when Cullins brought him over in good style on our twenty-five line. Here a series of scrums ensued, and by a piece of loose play, Guy's forwards worked the ball to the mid-way line. One of the opposing half-backs then got the ball and kicked, the Croydon men backed up well, and it looked dangerous for Guy's, but Harrison fielded well and found touch with an excellent kick. A scrum resulted, the Guy's forwards got the ball, heeled it out smartly to Wetherell, who started the back division off; a grand bout of passing then took place in which all the back division took part, and the ball eventually reached McEvedy, who again scored; Morgan took the kick, in which he was successful. Half-time was then called and Guy's were leading by 1 goal, 1 try to nil.

Croydon kicked-off, and the ball was well returned by Thomas. A scrum was formed, during which the Croydon forwards got the ball and rushed it, McEvedy saved, and for a while play was of an even character. The Guy's forwards, who got the ball far more frequently than their opponents, were playing with a lot of dash, heeled out well, and Morgan, neatly picking up a bad pass, ran and passed out to Thomas, who scored on the right; the kick failed. Slight delay was now caused owing to Wetherell having to rebind his semilunars. When this operation was performed, Croydon dropped-out, and a scrum was formed, again the Guy's three-quarters got the ball. One of the Croydon halves was off-side and a free kick given; O'Brien essayed a drop goal which, however, failed. Orpen fielded well and found touch. From a scrum the Croydon right wing broke away, but was pulled up by Morgan; from the scrum which followed, the Guy's forwards wheeled, and taking the ball with them gained a lot of ground. At this period of the game Wetherell retired hurt, and Thomas came out of the scrum to take his place. O'Brien received the ball and kicking over the scrum, followed up; the Croydon full-back mulled it, and O'Brien, gaining possession, passed out to McEvedy, who scored wide out on the right; Morgan took the kick and landed a magnificent goal. Croydon kicked-off, and by this time it was so dark that it was hard to distinguish the players. A lot of loose play followed, during which the ball was gradually worked up to our goal-line, here one of the Croydon forwards picked up and scored between the posts, the major point was not added, and time was called leaving Guy's victorious by 16 points to 3.

Association Football.

GUY'S v. CHESHUNT.

(Guy's, 2 goals; Cheshunt, 2 goals).

This match was played at Cheshunt on Saturday, December 8th. Our opponents losing the toss kicked-off, and by means of their centre and inside forwards immediately dribbled the ball through our defence, and scored with a swift and high shot which Collins could make no attempt at saving. Appearing to realise the position, Guy's then played a hard game, neither side holding any marked advantage for some time, till, by good passing on the right wing, Edey took the ball up the ground and centring well, enabled Milson, who had closely followed up, to score our first goal, and half-time was reached without any further score.

From the beginning of the second half Cheshunt, mainly through their right wing, played a very forcing game, putting in several good shots, which Collins saved well, till at length a low and difficult shot from their left wing gave them the lead. It now became our opponents turn to play a defensive game, and after several attacks, Chignell succeeded in scoring a good goal for the Hospital. During the last ten minutes' Guy's were continually pressing, and from a pass by [illegible]ber, Milson headed a third goal, but was ruled off-si[illegible]nd so a well contested game ended in a draw of two goals all.

In goal, Collins played a safe game, while Shepherd at centre-half played well throughout. Of the forwards, Milson and Barber showed the best form, the latter being distinctly unfortunate in not scoring. Team:—

Guy's.—E. A. Collins (goal); W. M. Robson H. Hogarth (backs); A. D. Crofts, N. P. Shepherd J. Cameron (half-backs); T. Edey, H. Barber, T. A. Chignell, E. L. Norton and T. F. Milson (forwards).

Papers by Guy's Men.

Abdominal Tumour (included fœtus) occurring in a child aged three months. Laparotomy. Death. By G. A. Wright, M.B., F.R.C.S., and D. S. Wylie, M.B., Ch.B. (Illustrated).—*British Medical Journal*, 17th November.

Some Notes on Cases of Movable Kidney, with remarks on them. By Henry Davy, M.D., F.R.C.P. Lond.—*Lancet*, 1st December.

Fundamental Points connected with the Pathology of Diabetes Mellitus. By F. W. Pavy, M.D., LL.D., F.R.S. —*British Medical Journal*, 1st December.

With Dr. Savage at Bethlem Royal Hospital. IV.—*Clinical Journal*, 28th November.

Death.

HALE.—On November 4th, at Barrow Hill, Chesterfield, Derbyshire, Thomas Frederick Hale, M.R.C.S. Eng., L.M., L.S.A., in his 74th year.

Ed.—L. E. S.

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